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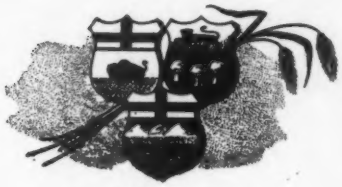

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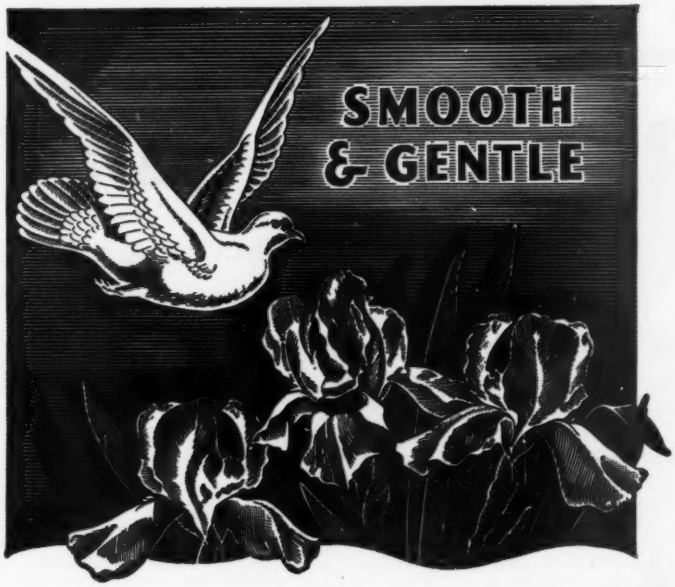

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The Manitoba Medical Review

Vol. 33 DECEMBER, 1953 No. 10

Surgery

Diverticulitis of the Sigmoid

P. H. T. Thorlakson, M.D.

Department of Surgery, Winnipeg Clinic

Diverticula of the colon are protrusions of the mucous membrane of the bowel through the circular muscle coat at points of weakness. These are created by the penetration of the wall of the colon by its blood vessels. Spasm of the circular muscle with increased intraluminal pressure contributes to the formation of these mucosal herniations devoid of a muscle layer. The appearance of the diverticula varies depending upon the stage of development but they never attain much size. They may be described as wedge-shaped, conical or flask-shaped. The sacculations may involve the entire colon (Fig. 1) or may be limited to a small segment (Fig. 2). In approximately thirty per cent of cases, the lesion is confined to the pelvic colon ((Fig 3). Although they may occur in younger patients, the incidence of diverticula increases with advancing years. Thus, at thirty-five years of age the occurrence rate is only 5 per cent but its frequency attains 50 to 60 per cent by the eighty-fifth year.

Diverticulosis coli causes no symptoms but is often associated with the peculiar type of constipation characteristic of a spastic colon. The management of the condition is that of spastic, irritable colon with constipation. The clinical importance of diverticulosis coli is due to its high incidence and possible complications. The flaccid wall, narrow neck, faecal content, and poor drainage are the factors responsible for the complications which vary in extent and severity from mild inflammation to acute intra-peritoneal suppuration, fistula formation or obstruction.

Diagnosis of Diverticulitis

Diverticulitis may be acute, sub-acute, recurrent or insidious and chronic in its course. Its symptoms and signs vary with the severity and duration of the inflammatory reaction: lower abdominal pain and tenderness, increasing constipation, fever, leucocytosis, pelvic mass, blood in the stool, passage of air through the bladder (pneumaturia), abdominal fistulae and rarely vaginal discharge.

Rupture of a small peri-diverticular abscess with pelvic peritonitis may occur with dramatic suddenness without previous history of colonic symptoms. The condition simulates acute pelvic appendicitis. On the other hand, the course may be so silent as to produce a mass in the pelvis which may be discovered only on examination for an unrelated condition such as uterine prolapse.

While blood due to local ulceration may be noticed in the stool, its occurrence should always suggest the presence of a benign adenoma or malignant tumor. Fistula between the colon and the bladder is a serious complication which could be prevented by early operation. Bladder irritability associated with diverticulitis suggests that

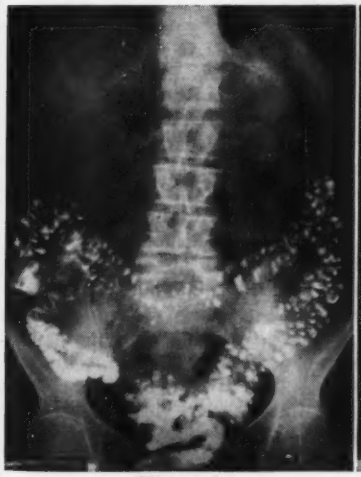

Figure 1
Generalized Diverticulosis

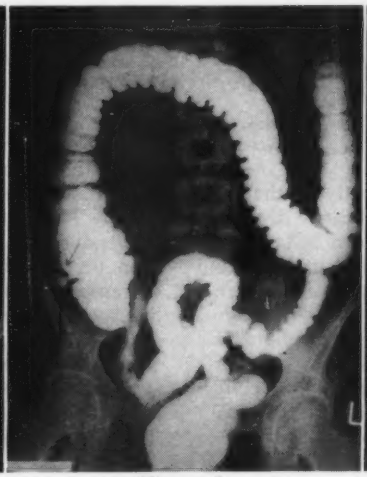

Figure 2
Single Diverticulum of Caecum

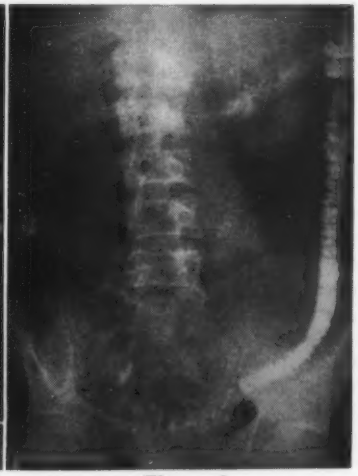

Figure 3
Diverticulosis of Sigmoid

the peri-diverticular inflammatory process involves the bladder wall and may perforate this organ. Increasing constipation with colicky pain suggests a degree of mechanical obstruction due to peri-colic fibrosis or increased spasm and edema. There have been two cases of colo-vaginal fistulae in my series. Both cases had previously been subjected to total hysterectomy.

A positive diagnosis can be established only by radiography. Rarely, a single diverticulum may become inflamed and its neck obstructed by edema in which case the barium enema may reveal no abnormality. Sigmoidoscopy should be a routine examination in all patients complaining of rectal and colonic symptoms. Its chief value is in excluding a neoplasm in the lower sigmoid and rectum. Occasionally, the ostium of a diverticulum is observed. Cystoscopy may be employed to observe the presence of edema and the exact location of a fistula in the bladder and its relationship to the left internal orifice. This, however, is not essential.

Differential Diagnosis for Carcinoma

Although there is no causal relationship between diverticulitis and carcinoma of the colon, their co-existence (Fig. 4) may lead to serious difficulties in diagnosis and treatment. A distinction between these conditions may not be possible in some cases until the lesion has been resected and the lumen of the bowel laid open for inspection. The radiological differentiation has been summarized as follows:

1. In diverticulitis, the mucosal pattern is intact in the involved areas whereas, in carcinoma, the pattern is lost and the constricted area is smooth, having the so-called "tunnel" appearance.

2. The proximal and distal limits of carcinoma, with very few exceptions, are sharply outlined and present what is described as a "cuff" formation (Fig. 5). The margins of diverticulitis have long, sloping edges (Fig. 6).

3. The involved area in diverticulitis is frequently much greater, being in most cases 10 to 15 centimeters in length. The annular defect in carcinoma, on the other hand, is more often only 1 to 5 centimeters.

4. One or more diverticula, directly in the involved portion of the bowel, indicates diverticulitis particularly if mucosal pattern is present. On the the other hand, diverticula around a neoplasm but not directly in the involved area, are not uncommon.

5. Annular carcinoma can occur anywhere in the colon but diverticulitis producing an annular defect does not occur above the crest of the ileum.

Treatment of Diverticulitis

The treatment of mild, uncomplicated diverticulitis during a remission, is similar to that prescribed for a spastic colon. However, during an attack, it is necessary for the patient to remain in bed, receive anti-biotics intramuscularly, sulphathalidine and mineral oil by mouth to soften and reduce the bulk of food residue, warm water and oil enemata, local heat and codeine for pain, and a restricted diet.

Ten years ago, surgery was usually postponed until the more serious complications of abscess, obstruction or fistula had already occurred. With improvements in the preparation of patients and markedly lowered operative mortality, surgery should be performed earlier in an attempt to prevent these late complications. Surgery is now indicated in the presence of persistent or recurrent local symptoms and signs of diverticulitis and the presence of a palpable mass.

The pre-operative preparation consists of thorough cleansing of the large bowel with castor oil and daily large enemas; sulphathalidine, grains 30 q.i.d. for four or five days prior to operation (this drug is inexpensive, safe and effective); low residue diet, restricted during the last twenty-four hours to soft-cooked eggs, thin slices of white bread with butter, skim milk, tea, small amount of fruit and forced glucose drinks.

The ideal operation, before serious complications have occurred, is a one-stage resection of the involved segment of bowel and open end-to-end anastomosis. For its accomplishment, this may require mobilization of the splenic flexure and descending portion of the colon. A moderate degree of narrowing or even obstruction can now be treated safely by resection without preliminary transverse colostomy. The necessity for the establishment of a proximal "safety valve" by caecostomy or colostomy at the time of the resection depends on several factors such as the degree of obstruction, the completeness of the pre-operative cleansing of the colon, the extent of the pelvic dissection required, the involvement of contiguous structures and, in general, the surgeon's judgment as to the security of the anastomosis.

Treatment of Complications

The serious surgical complications of diverticulitis of the sigmoid are acute peritonitis, localized abscess, obstruction, and fistula (Fig. 7). The immediate treatment of peritonitis or abscess is simple drainage, anti-biotics plus intravenous fluids and gastric suction as indicated. Exteriorization of the involved segment is seldom possible because the lower sigmoid is the area most commonly involved in serious complications. Transverse colostomy may be necessary in those rare cases in which free perforation with faecal contamination occurs. The treatment of marked obstruction and fistula (either vesico-colonic or sigmoido-cutaneous) is transverse colostomy followed in two or three months by resection and end-to-end anastomosis unless malignancy is suspected.

Summary

The treatment of diverticulosis coli and mild uncomplicated diverticulitis is medical. The treatment of recurrent or complicated diverticulitis is surgical. It is not always an easy matter to select the time at which a particular case ceases to be a medical problem but, with good reason, the tendency is towards earlier operation before a major disaster overtakes the patient.

Figure 4 — A large inflammatory tumor of the recto-sigmoid, showing multiple diverticula. The mass was honeycombed by inter-communicating tracts and there was marked peri-diverticular fibrosis. The mucosa is thrown into thick deep circular folds by the foreshortening of the bowel, the result of the fibrous contracture. These thick folds were congested and ulcerated. Patient gave a history of chronic diverticulitis extending over a period of many years (proved radiographically), but had been passing gross blood and pus for six months prior to examination.

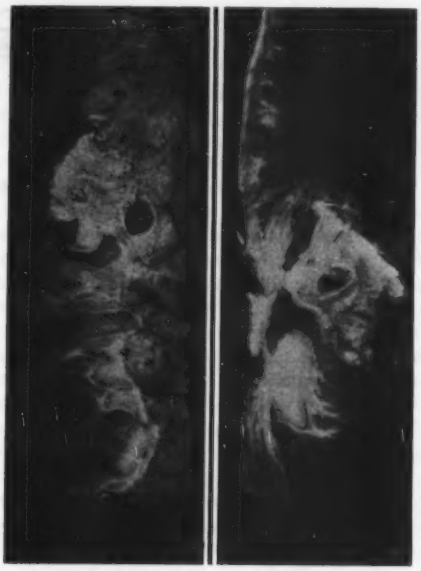

Figure 4 **Figure 6**

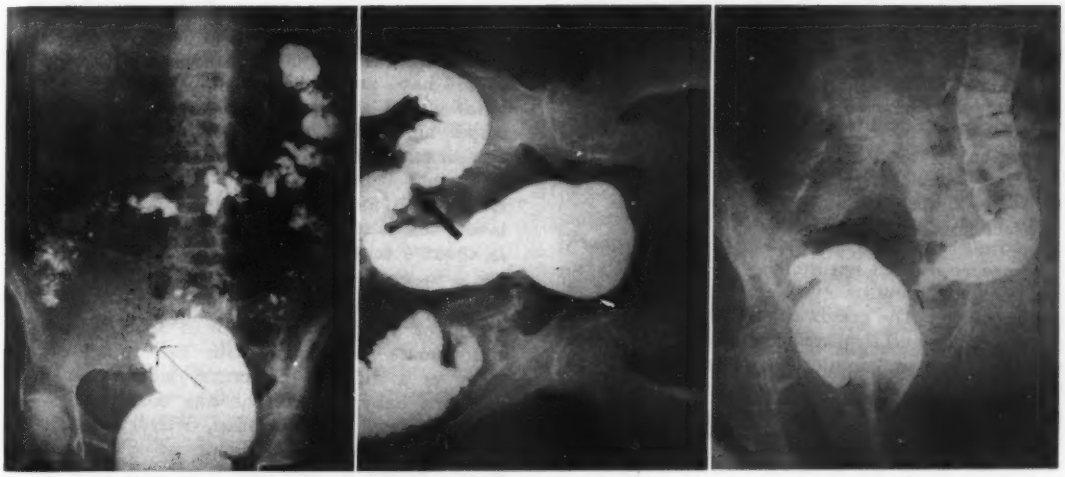

Figure 5 **Figure 7** **Figure 8**

Figure 5 — Carcinoma (large arrow) and diverticulosis (small arrows) of sigmoid.

Figure 6 — A recto-sigmoid tumor produced by chronic diverticulitis, which may be difficult to distinguish from carcinoma.

Figure 7 — Carcinoma of sigmoid.

Figure 8 — Obstruction in sigmoid due to diverticulitis.

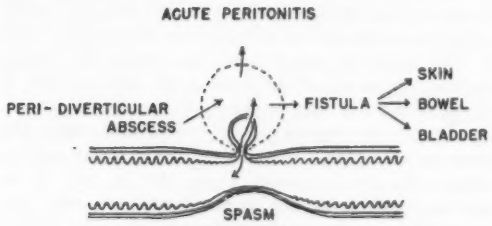

Figure 9
Acute diverticulitis with complications

Obstetrics

Prolonged Labor

H. Guyot, M.D.
Chairman of Department of Obstetrics
St. Boniface Hospital

I will limit my remarks to the etiology of prolonged labor.

It is generally agreed that uterine inertia is by far the most common cause of prolonged labor. We must differentiate between the two main types of uterine dysfunction i.e. the atonic and the hypertonic.

In the atonic type of uterine inertia the contractions are weak, of short duration, irregular and infrequent from the start. They are not very painful at first and it is difficult to know if the patient is really in labor. The cervix is only 1 or 2 fingers dilated, thin and soft, and progress is slow. After 24 or 48 hours of this type of desultory labor the patient begins to worry, she becomes exhausted from lack of sleep and food, she complains more bitterly of pain and wonders why the baby does not come. The over-sympathetic husband and relatives are not usually of great help. The situation is not serious as long as there are no complicating factors such as ruptured membranes, malposition or disproportion, foetal or maternal distress. Very often in these cases the obstetrician is tempted to interfere too early by applying forceps when the cervix is not fully dilated or by doing an unnecessary caesarean section.

In the hypertonic type the uterine contractions are strong and well sustained from their onset, they are colicky in nature, the pain is mostly in the back and persists even after the contraction has subsided. The cervix dilates very slowly and remains thick and firm. The relaxation of uterine muscles is never complete between contractions. The lower segment remains hypertonic and resists passive dilatation. We then speak of inco-ordinate uterine action, whereby the upper segment is working against a resisting lower segment and cervix.

Rarely, in its most severe form, the circular fibres go into persistent spasm and we then have a typical constriction ring. The commonest site for this is at the junction of the upper and lower uterine segment. This hour-glass constriction is formed over a depression of the fetal ovoid, usually in the region of the neck, and stops the progress of cervical dilatation. On vaginal examination the cervix hangs loose like a cuff or is poorly applied to the presenting part and the diagnosis is confirmed by palpating the ring higher up in the uterus.

Presented at a round table conference, Canadian Medical Association Convention, Winnipeg, June 19, 1953.

A constriction ring must be differentiated from a pathological retraction ring (or Bandl's ring) which is seen in obstructed labors at the junction of the thick, contracted upper segment and the thinned-out passive lower segment. It does not necessarily form over a depression of the child's body and is not a cause of prolonged labor but comes as a result of obstruction.

The etiology of inco-ordinate uterine action is not clear but there are certain factors which appear to bring this on. I will mention a few:

1. The fear of labor and its complications, even the fear of death, is commonly experienced by nervous, tense, apprehensive women, especially primiparas. The influence of the mind on the progress of labor has been emphasized by Dr. Read's well known dictum: "Tense woman, tense cervix." It is therefore important to gain the patient's confidence and to reassure her at the first prenatal visit. To most of us the taking of pelvic measurements appears to be a waste of time, but to an apprehensive young primipara this part of the examination is essential, and it makes her feel much more confident if she is told that her measurements are quite normal and that she should have an easy labor. Throughout the prenatal period and during labor we should try to dispel all doubts by words of explanation and reassurance and avoid fright provoking terms such as "pains," tears," "stitches," forceps" and "hemorrhage." In most papers published on prolonged labors the proportion of primiparas to multiparas is about 4 to 1, and the psychological factor appears to play an important part.

A multipara may also have good reasons to be afraid of a subsequent labor if she has had an unfortunate experience with her first delivery such as a difficult prolonged labor, perhaps a stillborn baby, and if she has been told, quite unnecessarily, that her next delivery should be by caesarean section. Some of these women simply refuse to bear any more children.

An observation which is mentioned by most authors is that if a primipara has had a prolonged labor due to inco-ordinate uterine action she is not likely to repeat the same thing at her next delivery.

2. Inco-ordinate uterine action is often associated with an occiput posterior or an occiput transverse position, a mild disproportion or an asynclitism. The malposition seems to be a cause of faulty uterine action rather than the result of it. Good, effective contractions during the first and second stage seem to depend on how well the presenting part fits in the lower segment, over the cervix or on the perineum.

3. The use of oxytocic drugs during labor may initiate abnormal uterine action and will certainly aggravate the condition if the uterus is already irritated and spastic. The same applies to intra-uterine manipulations.

4. Another factor which is sometimes present is some congenital maldevelopment of the uterus such as a bicornuate or a unicornuate uterus. However the faulty action of the uterus in these cases is more evident in the third stage when the placenta does not separate and has to be removed manually.

It is therefore important to recognize the two types of uterine dysfunction i.e. the atonic and the hypertonic, before deciding on the method of treatment. The first requires time, alternate periods of rest and stimulation. The second requires sedatives, analgesics and antispasmodics such as morphine, demerol, barbiturates, amyl nitrite; oxytocics are contra-indicated.

We can differentiate between the two types during labor by observing the general behavior of the patient, by palpating the abdomen during a few contractions and by doing a vaginal examination, when required, to find out the condition of the cervix and the position of the presenting part. In cases of prolonged labor we rely too much on rectal examinations which are not always very helpful or accurate. One careful vaginal examination very often gives us more information than ten rectals and is less dangerous for the mother.

During the second stage the abdominal muscles play an important part in the expulsion of the baby. This stage may be unduly prolonged in some cases when the muscles are poorly developed or when the recti have been separated by repeated previous pregnancies. A tight abdominal binder often works wonders. Or a patient may refuse to bear down because she is afraid of pain. Encouragement and sedation are then indicated.

Positional dystocia — The cause of prolonged labor is often ascribed to an occiput posterior position or to a transverse position of the occiput after engagement. When labor is prolonged beyond 24 hours we often hear the comment of nurses or internes that "this must be an occiput posterior." And if a vaginal examination is done and the sagittal suture is found to lie transversely in the pelvis, then this supposedly abnormal position is sure to be blamed for the delay. This is not always true because in the majority of cases the head engages normally in the transverse diameter of the inlet. Uterine inertia, poor flexion or rigidity of the lower segment and cervix are more often the cause. In most of these cases the occiput will rotate anteriorly if the contractions are adequate and if given sufficient time. Occasionally, when flexion is poor, the occiput will rotate in the hollow of the sacrum or the occiput remains in a transverse position as it descends in the mid-pelvis. This malposition is then a real cause of prolonged labor and should be corrected, but only after full dilatation of the cervix.

A breech presentation is not a common cause of prolonged labor unless it occurs in an elderly primipara or when the baby is large. A trial of labor is not usually feasible but if labor is prolonged beyond 24 hours without any sign of engagement or progress a disproportion may be suspected. An X-ray does not give us much information as far as the size of the foetal skull is concerned and sometimes, on account of distortion, may be misleading. But there is a radiological sign which should be looked for in breech presentations, that is a flattening of the top of the head, caused by pressure from the fundus, which usually indicates a large baby.

Cases of face presentation, impacted at the inlet, indicating a gross disproportion, cases of brow and transverse presentation should be recognized early in labor and proper treatment instituted. The importance of a radiological and a careful vaginal examination is obvious to prevent the grave consequences of obstructed labor, namely, fetal death and rupture of the uterus.

Cephalo-pelvic disproportion as a cause of prolonged labor is equally as important as positional dystocia. For an experienced obstetrician, gross disproportion does not present a difficult problem because it is recognized early in labor and is treated accordingly. It is the borderline cases which give most trouble and worry because a decision cannot be reached until the patient has had an adequate trial of labor. An X-ray will give us valuable information as to size and shape of the pelvis, relative size of the foetal head, position and presentation, etc., but it should not be the only means of arriving at a decision for or against caesarean section. The progress of labor, as determined by careful supervision, including one or two vaginal examinations, is far more important than the radiological report.

We must take into consideration the strength, frequency and duration of contractions, the amount of engagement or descent of the foetal head, the amount of molding, the caput formation. The dilatation of the cervix is a fairly good index of the presence or absence of insuperable disproportion. Usually the cervix will not dilate satisfactorily if vaginal delivery is impossible.

Since most cases of trial of labor last 24 hours or more, they may be included in a discussion of prolonged labor. There are, of course, circumstances where a trial of labor of more than 8 to 12 hours would be dangerous when there are signs of fetal or maternal distress, and a decision for caesarean section would be made early. The question is not so much how many hours of labor but what the patient can accomplish with good strong pains.

The type of pelvic contraction should also be taken into consideration. In a flat contracted pelvis once the biparietal diameter has passed the inlet, labor progresses rapidly and is terminated easily. In a generally contracted pelvis or in mid-pelvic contraction labor is prolonged and a successful delivery is not expected until the head is well down in the pelvis. In outlet contraction, when the sum of the interischial tuberous diameter and the posterior sagittal diameter is less than 15 cm, a trial of labor becomes dangerous. When the head has reached the outlet and cannot be brought through it is usually too late to do a section.

When disproportion is accompanied by uterine inertia or early rupture of membranes, as it often happens, the problem is even more difficult. Good contractions are necessary to mold the head through a relatively small pelvis and if the contractions are weak there is no way to tell if the head will go through.

A large baby is often a cause of disproportion and prolonged labor, especially in a multipara. Many times we are lulled into a false sense of security because the patient has had 5 or 6 babies, weighing around eight pounds, without too much difficulty. Then if she has a ten or twelve pound baby there is gross disproportion and danger of rupture. Other causes of abnormal fetal size, besides multiparity, are diabetes, hydrops foetalis and hydrocephalus.

I will simply enumerate other causes of prolonged labor which are not common but still they should be kept in mind:

1. Cervical dystocia. A rigid cervix due to conization, deep repeated cauteries, or cervical scarring resulting from tears or surgical repairs.

2. An elderly primipara with rigid cervix and firm vaginal outlet.

3. Premature rupture of membranes at 7 or 8 months when the cervix is thick and firm, not ripe.

4. A prolapsed, elongated, oedematous cervix, although this is rare.

5. A thick, oedematous anterior lip often associated with a malposition.

6. A large cystocele and rectocele.

7. A distended bladder may prolong labor beyond 24 hours.

8. The administration of analgesic drugs too early in labor and in too large doses. The same applies to spinal and caudal anaesthesia.

9. Obesity—Women weighing 200 pounds or more.

10. A pendulous abdomen with marked anteflexion of the uterus.

11. Adhesions between the uterus and the anterior abdominal wall after a classical caesarean section or after a ventral fixation for correction of a retroverted uterus. In these cases the cervix is usually displaced posteriorly, sometimes anteriorly.

12. A distended uterus, as with twins and hydramnios, although in these cases post-partum haemorrhage is the more common complication.

13. Multiple fibroids affecting the contractile power of the uterus or a large fibroid situated low posteriorly causing an obstruction.

14. Ovarian cysts, especially dermoids, in the pelvic cavity.

15. A pelvic ectopic kidney.

16. Rare tumors of the bladder and rectum.

Medicine

Some Rehabilitation Problems of the Polio Patient*

M. H. L. Desmarais, M.R.C.S., D. Phys. Med.

With the present polio epidemic on the decline, the stage of disease which concerns us most at present is the stage of Adaptation and Recovery. Instead of discussing the management of the acute illness when our main concern was to relieve pain and muscle spasms, to maintain good body alignment and prevent early deformities, it would perhaps be opportune to discuss here some aspects of the common complications and deformities which may arise both in the young and in the adult as a result of faulty body alignment. I shall not touch on the orthopoedic management of these problems but will give you an outline of what physical methods of treatment can achieve to overcome some of these deformities.

Apart from involvement of the motor neurones, rapid changes also occur in the muscle fibres and fibrous elements of the body. These changes take place early in the disease and account for more structural alterations than could be explained by those produced by spasm and disuse. Contractures may interfere with function; on the other hand, some tightness in the supporting tissues may sometimes act as an additional support to already weakened muscles. In dealing with the effects of healing processes and fibrosis, good judgment is required to decide on the best course to follow. Indiscriminate stretching of contractures can do more harm than good; over-stretching of tendons and muscles in the long run may reduce the mechanical efficiency of weakened muscles. Tears will produce scar tissue and adhesions which will further limit elasticity. The ability to recognize early tightness and to determine the amount of mobilization required to prevent deformities and ensure maximum mechanical efficiency can be acquired only by experience.

*Presented at the monthly meeting of the Winnipeg Medical Society, October 23rd, 1953.

All deformities result from the persistent faulty alignment of body segments during rest and activity and these become more obvious in the child as growth proceeds and the uneven pull of shortened, weak or inelastic muscles produce their strains and stresses on the skeleton. The body frame-work of the adult is more solid and the older patient in whom growth is complete does not demand so vigilant a watch on progress as the young child does. The handling of these two groups of patients is totally different. The little child has no worries and no responsibilities of its own and time is of little importance in his rehabilitation; the paralyzed adult has many anxieties and very often for economic and social reasons the opportunity of optimum recovery must be sacrificed for the future plans for his career.

In analyzing the factors which play a part in the production of deformities, the additional effects of gravity and the habitual positions assumed by the body must also be borne in mind.

Any faulty body alignment may produce permanent and fixed deformities and the slight undetected muscle weakness of today may leave in its wake gross deformities in the years to come. Those with recovering paralysis should be reviewed as often as required, and this is of great importance in the case of young children.

Many localized lesions affecting muscles and joints are potential precursors of Scoliosis and in dealing with these, one's attention must not be over-concentrated on the paralyzed muscle and its re-education and the promotion of good range of movement but care must also be taken to maintain good posture and body alignment.

As an example, a child with one lower limb paralyzed will tend to overuse the unparalyzed one. He will hitch up the pelvis on the unaffected side producing an apparent shortening of this limb. A Scoliosis convex to the side of the paralyzed limb will develop with an adduction deformity of the unaffected hip. In these cases, the relationship between the head of the femur and acetabulum is disturbed and spontaneous dislocation of that hip may become a real danger. This can be overcome by daily passive mobilization of both hips through their full range of movement and by judicious splinting. If the deformity persists, the back must be kept mobilized by exercises to ensure a successful spinal fusion at a later date.

Some muscles seem to fare badly when affected and their rate of recovery is usually slow and often incomplete.

The deltoid is one of these. This is often accompanied by a "frozen shoulder," with limitation of movement especially in abduction and external rotation. When the patient attempts to abduct the arm, the shoulder is raised and movement takes place from the scapula instead. This "trick movement" is easily acquired and should be corrected at an early stage of muscle re-education. It is better to ensure only a small range of pure arm abduction from the use of the supraspinatus and weak deltoid than to allow this "trick movement" to take place. If at a later stage recovery in the deltoid is not apparent, then abduction can be encouraged by the forward rotation and hitching of the scapula.

Scoliosis attending involvement of the shoulder girdle is a real danger. The hitching up of the shoulder can be a contributing factor in causing a disturbance of good alignment of the body.

Sometimes the degree of recovery in an upper limb will be the governing factor which will determine when a patient will be allowed to start ambulation. If the lower limbs are also affected and the patient will eventually require the use of braces and crutches and the weakness in the upper limb promises complete recovery, it is sometimes advisable to wait until sufficient power has returned in the upper limb before weight bearing is allowed.

Weakness of the abdominal muscles is still another predisposing factor which will influence the alignment of the spine. This is particularly true of the oblique groups and to a less extent of the transversalis. Caution must be exercised in allowing these patients to sit up or assume the erect posture. When associated with weak back musculature, still more prolonged recumbency should be enforced.

Asymmetry of the sterno mastoids, and more so if associated with involvement of the upper limb, can be considered as an accelerating rather than a causative factor in producing Scoliosis.

Weakness and/or contractures in the Quadratus Lumborum, the Ilio Psos and Erector Spinae, through their attachment to the pelvis and to the spine, will tend to produce disturbances of posture. The shape of the curve will vary according to the direction of maximum pull.

There are many other accelerating and causative factors in the production of Scoliosis;

The disparity in length of the lower limbs is too obvious a cause to discuss at length.

The loss of bulk in the region of the thigh and buttocks will cause tilting of the pelvis in the sitting position. This can be prevented by simple explanation to the patient and letting him find his own devices in the use of a small cushion and sloping chairs, etc.

Contracture of the Ilio-Tibial band is not in itself a direct causative factor of Scoliosis, but by producing flexion an abduction deformity of the hip and apparent shortening of the limb will indirectly cause tilting of the pelvis and marked

degrees of Scoliosis and Lumbar lordosis. Daily stretching of this band whether contractures are present or not, has become a routine part of treatment. This is especially important in children because this condition can often be overcome if detected and treated early.

The opponens is another muscle which has a tendency to show poor recovery and paralysis of the muscle, which is sometimes selective, can be a great handicap to the patient. Grasp and pinch are the two most important functions of the hand. With a paralyzed opponens, pinching is impossible and only grasp remains. Many operations involving the transplant of tendons have been devised to overcome this disability. Before this is undertaken, however, the thumb must be kept mobile by daily passive movements, and the use of an opponens splint will keep the thumb in its best functional position and prevent adduction contractures.

Problems of varying magnitude are encountered in the caring of the Polio patient. In the lower limb, the Anterior Tibial is more commonly affected than the evertors; it is always associated with weak invertion and dorsi flexion of the foot, and when there is inbalance of muscle power between the evertors and invertors of the foot, some form of bracing with a drop foot stop is indicated, to prevent foot drop and valgus deformities of the ankle.

Another interesting syndrome which calls for attention here is the combined weakness of the hamstrings and calf muscles. This is of particular interest in children as linear growth of the tibia and the overall growth of the bones of the foot will be retarded. Weight bearing in these cases should be delayed until good power has been recovered in the gastrocnenius muscle.

The general management of the Polio patient, and in particular the handling of such problems mentioned above, require very close team work in which the Orthopoedic surgeon plays a very important part. Each case is a problem of his own and individual attention to gross defects and to details in particular, is necessary to achieve the fullest functional result possible. The cure of the patient, however, does not end with the achievement of good function only. The necessity of vocation training to get the patient back to work is of paramount importance and all steps taken in his medical care must aim at making it easier for him to earn his living and become again a useful member of the Community.

In Lighter Vein

The Medical Sermon and the Medical Prophecy

S Vaisrub, M.D., M.R.C.P. (Lond.), F.R.C.P.(C), F.A.C.P.

While browsing through the musings of the Peripatetic Correspondent in the November 5, 1952, issue of the Lancet, I stumbled upon the following advertisement reprinted from the Bath Chronicle, Thursday, March 20, 1777:

"WANTED, for a family who have bad health, a sober, steady person, in the capacity of doctor, surgeon, apothecary, and man-midwife: He must occasionally act in the capacity of butler, and dress hair and wigs: He will be required to read prayers occasionally, and a sermon every Sunday evening. The reason for this advertisement is, that the family cannot any longer afford the expences of the physical tribe, and wish to be at a certain expence. A good salary will be given. N.B. He will have liberty to turn a penny in any branch of his profession when not wanted in the family."

A wave of nostalgic sentiment swept over me as I read these brief lines. What an ideal "set up" for a family physician! What perfect background for the practitioner of true Holistic Medicine! Surgery, Medicine, Pharmacy harmoniously blended with no departmental barriers of narrow specialism to separate them. Doctor and patient bound together not by casual contact at the bedside or the office, but by the intimate relationship between a butler-hairdresser and his master and mistress (in the respectable sense of the word). The opportunities of learning all about the whole man (and the whole woman, of course) while powdering the Master's wig or combing the hair of milady in her scented boudoir stagger the imagination. This, indeed, was the golden age of holistic medicine.

There is also a promise in these lines of an ideal solution of the problem of the physician's recompense. The "liberty to turn a penny" with its implied free enterprise is happily combined with the security of "estate medicine."

Appealing as all these attractive advantages may have been to the 18th Century practitioner of the Art of Medicine, the pièce de resistance of this fascinating advertisement must have been, I am sure, the reference to the weekly Sermon. This was the bait, which the advertiser knew, no doctor could resist, for the flair for preaching has been one of the most constant attributes of the medical craft since the dawn of history. Whether in the sanctum of his office, the rostrum of the lecture hall, or the informal palaverium with his friends, the doctor loves to preach and admonish.

Evils of alcohol, tobacco, overwork, gluttony, high living, etc., are all favorite subjects. The doctor is, however, at his best in his preaching capacity when he directs his sermons at his professional colleagues. Inaugural, valedictory, annual orations, addresses to medical Societies are the favorite vehicles of expression, as are the learned editorials commenting upon them. These sermons can be recognized at a glance by their titles which follow certain discernible symbolic patterns. These may be spatial usually with emphasis on movement and direction e.g. "Whither Medicine?" "Whither Surgery," "Whither Pathology?" "Whither Tuberculosis," "Progress in Medicine," "Progress in Obstetrics," etc., "The New Approach in Medicine," "The New Approach in Gynecology," "Medicine at the Crossroads," "Surgery at the Crossroads" (indeed as one of the anonymous peripatetic correspondents remarked "the world's crossroads appear to be thronged by leaders of medicine looking before and after the pining for what is not"), "Medical perspectives," "Medical vistas." The symbolism is at times military: "Medicine on the March," "Advances in Medicine," "Medical Triumphs," "Surgical Victories," "Combined Operations in Surgery." The titles may belong to the temporal Sphere, "Medicine Today," "Medicine, Past, Present and Future," "Medicine what of Tomorrow?" "The New Era in Medicine," "Fifty years of Medicine." They may be philosophical: "Reflections on Medicine," "Random thoughts on Medicine," "Philosophy of Medicine," "Metaphysical basis of Pathology," "Changing Concepts in Medicine," "The Changing face of Medicine." "Is Medicine here to stay?" They may even be poetic: "The tree of Medicine," "The Flower of Medicine," "The Fruits of Obstetrics," "The Rising tide of Medical Knowledge," "The New Dawn in Medicine." Not infrequently they are crisp and matter of fact: "Specialism and the General Practitioner," "The Doctor and the Patient," "Why are we Doctors?" "Medicine is not Enough," or just "Trends."

In contrast to the dazzling variety of titles, the contents of these papers are fairly uniform, predictable, almost stereotyped. They fall usually into two patterns. The commonest can be best described as the deploring and appealing type, the true sermon. It usually consists of three parts. The first part is a lengthy review of the progress of scientific medicine in the past 50-200 years. Advances in diagnosis and therapy are referred to with pride. Antiseptics, anaesthesia, insulin, vitamins, antibiotics, hormones and other milestones of medical progress are mentioned with due reverence. The concomitant steady growth of specialism is noted and the necessity for it grudgingly acknowledged. The second part is a tirade against the new trends. It "deplores" the rise of the cold impersonal specialist, and the eclipse of the kindly family doctor with his intimate knowledge and understanding of the problems of his patients. The trend toward mechanization of medical diagnosis is also pari passu "deplored," while the virtues of a good history and physical examination are extolled. The old time interest in the succussion splash and crack pot sound is contrasted favorably with present day preoccupation with p-r intervals and phonocardiograms. The third part is the "appeal" and the "message." It appeals to the reader's emotions as well as intellect for reassessment of values, integration of concepts, better appreciation of the Art of Medicine and a broader approach to the patient's problems. The following are two typical examples: " . . . mature, humanistic, scientific procedures based on scientific observations and analysis of natural phenomena flexibly interpreted in the light of basic biologico philosophic postulates and integrated as far as possible with other disciplines and fields of human knowledge . . ."—". . . therapies based on aid and support to the innate healing, defensive adaptive and control mechanisms of the soma and psyche . . ." It can be readily seen that this part is more nebulous and less vigorous than the preceding denunciation.

The second type, the medical prophecy, can be best described as "inspirational." Its theme is the "glory of Medicine," its leitmotif—the "New Dawn," its content—the augury of greater things to come. Although not confined to the North American Continent, it flourishes here more luxuriantly than anywhere else. It rises and falls with the rising and ebbing tide of new discoveries. A rich crop followed the advent of antibiotics and more recently of Cortisone and ACTH. The following quotation serves as an illustration: . . . "There is a foreshadowing of changes to come. Psychiatry is astir, neurophysiology is crescent, neurosurgery flourishes and a star hangs over the cradle of endocrinology . . ." Having, thus, analyzed the medical sermon and prophecy one is tempted to speculate upon their causes, motivation and significance. Do they satisfy a real need, or are they just so much humbug? The latter point of view was brought to my attention rather forcibly not too long ago at one of the meetings of a medical convention by the following episode. While the speaker pontificated at length along the lines sketched above my neighbor to the left, a portly, distinguished looking gentleman seemed to be completely absorbed by the oration. Never taking his eyes off the speaker for a single moment, he listened in rapt attention appearing to hang on his every word. Suddenly as I was at the peak of my admiration for this rapport between speaker and audience, my neighbor turned toward me and said in a hushed whisper: "This is bull, isn't it?" To say that the serenity of the moment was broken would

be an understatement. A volcanic eruption could not have been more shattering.

A somewhat less disrespectful attitude but no less cynical is expressed in the view that medical sermons particularly those with emphasis on denunciation are intended as digs at the specialist and scientific physician by the older boys who are unable to keep abreast with medical progress, and lean rather heavily on medical lifemanship. These exponents of the Art of Medicine versus its Science are alleged by the cynics to feel ill at ease in the company of electrolytes and chylomicrons, and the sight of a cardiac catheter, unlike that of the urethra is as repugnant to them as it is unfamiliar. Hence their mistrust of "scientific medicine."

Plausible as it may appear on superficial examination, this view is totally untenable, for the speakers and writers responsible for these orations and papers are almost invariably top level scientists. They are leaders in their fields and neither ignorance nor petty motivation could be conceivably imputed to them.

Another cynical view is that these papers are a means of getting into print and receiving publicity and acclaim without doing any "honest work." To do original research or review the literature on some specific subject in order to write a scientific paper involves laborious and time consuming effort. To generalize and preach according to set patterns and well known formulas should, however, be easy. This view, logical as it may sound, completely disregards the effort that goes into the building the edifice of a medical oration. To seek new guises for old ideas is no easy task. The straws are there but the bricks are hard to make.

Other brazen critics of this literary genre, although acknowledging both the effort and skill that goes into its structure see in it only the expression of the author's vanity. The medical preacher, according to them, is bolstering his ego by playing philosopher. He fancies himself no longer as a craftsman plying his trade but as a sage, thinker, and guide to the perplexed. He inflates his ego by pretending to be something he is not. This view, of course, hardly merits any comment.

As we descend the ladder of cynicism we encounter the guilt theory. According to this view the medical sermon is motivated by a sense of guilt. The doctor has a vague sense of guilt toward the patient whom he subjects to too many investigative procedures in the hope of arriving at a diagnosis without spending too much time on taking a history and doing a thorough physical examination. The specialist has a similar feeling toward the general practitioner to whom he renders lip service by proclaiming him to be the salt of the earth, but whom he often treats as he would a backward child. This theory with its psychoanalytic flavor cannot be completely shrugged off. One must concede that it may have an element of truth in it, and that it may offer a partial explanation.

A much lighter and simpler explanation is proffered by the exponents of the "escape" theory. According to this view the medical sermon and prophecy are escapes from the dry scientific papers that fill medical journals and publications. What, indeed, could be more refreshing than to turn after perusing a paper on the inverted esophageal T-wave in a subject standing on his head in a swimming pool (filled with water) to one entitled "Medicine, what of tomorrow?" or after wading through a morass of graphs and figures, which try to prove the uselessness of a some useless drug in some obscure condition to find rest for the tired eyes and solace for the weary soul in a charming essay with the title: "The Promise of Medicine." Indeed if escape were the sole function of the medical sermon it would amply justify its existence.

Where do we go from here? Having indulged in a none too flattering critical analysis we are still left without an adequate explanation of the phenomenon of medical oration. Allowing for some partial truths in some of the views discussed one may well ponder whether it could be "all this and heaven too." One may wonder whether constant repetition has not dulled our perception to fundamental truths that lie hidden under the verbiage, and obscured from our view some deep thoughts and inspiring concepts that lurk behind the seemingly vague generalities. May the Medical Sermon and Prophecy not be precisely what they purport to be—sources of guidance, inspiration and hope?

In order not to run the risk of converting this paper into a sermon I shall let the reader supply the answer.

Ward Rounds of the Children's Hospital, Winnipeg

Case No. 53-2853

This three-day-old male infant was admitted 9 days ago with a history of vomiting bile-stained material after each feeding since birth, as well as a failure to pass meconium. There had been a normal gestation and delivery. Other details of the family history and personal history were non-contributory.

On physical examination it was noted that there was moderate dehydration, a distended, tympanitic abdomen, and a small amount of cream colored stool in the rectum.

Laboratory examination of the stool was negative for bile; Farber's Test demonstrated the absence of cornified cells and cholesterol crystals. An X-ray of the abdomen showed gas and fluid levels in the stomach with several dilated loops of intestine containing fluid levels, presumably in the small intestines. No gas was seen in the region of the sigmoid or rectum.

A diagnosis of atresia of the small intestine was made.

Pre-operatively, the baby received an intravenous consisting of 25 c.c. of isotonic saline and 250 c.c. of five per cent glucose in water over a period of five hours.

The post-operative course was uneventful. Meconium was passed per rectum on the second post-operative day. A flat film of the abdomen at this time showed gas in the colon, extending as far distally as the rectum.

Dr. Medovy:

I should like to add that the vomitus of this infant was banana-yellow in color and that appropriate chemical tests demonstrated the absence of bile. This demonstrated that any obstruction was below the second part of the duodenum. Furthermore the results of the Farber's Test indicated a complete obstruction.

Dr. Clark:

The differential diagnosis in this case was: (1) intestinal atresia; (2) meconium ileus, and (3) volvulus of the mid-gut.

On physical examination, abdominal distention was very marked. Furthermore, the X-ray film of the abdomen showed distention of small bowel loops with fluid levels. Such abdominal distention is rare in volvulus of the mid-gut. The reason for this is that rotation of the mid-gut shuts off the duodenum almost completely or even completely. However, the middle of the transverse colon is only partially obstructed when the mid-gut twists, so that gas can pass into the distal colon. This explains the fact that obstruction due to mid-gut volvulus is often associated with a scaphoid rather than a distended abdomen. In the present case there was no gas in the distal colon and the

abdomen was distended rather than scaphoid. This therefore rules out volvulus of the mid-gut.

In meconium ileus, the loops may be dilated but sometimes the thick meconium in the terminal ileum can be palpated. Further, the presence of this peculiar type of meconium in the terminal ileum gives to the X-ray a "ground-glass" appearance. This was not the situation obtaining in the present case. A diagnosis of intestinal atresia was therefore made.

At operation, eight hours after admission, an area of atresia was found at the junction of the ileum and jejunum. The bowel was in continuity, but was occluded at the site of the obstruction for a distance of about one inch. The jejunum was markedly distended, but the bowel below the obstruction was about the size of a wooden match.

This narrowed bowel below the obstruction was distended by injecting normal saline. A lateral anastomosis was done with two layers, an outer silk and an inner cat gut. The remainder of the small bowel was then carefully explored to rule out any other area of atresia.

In Boston, Gross and his associates recommend a Mikulicz's type of resection in low ileal obstructions. Dr. Ferguson will no doubt describe this method of handling these cases to you. This may be a preferable way of handling low ileal obstructions, but in obstructions in the upper ileum or jejunum it produces an ileostomy. In such instances there is a marked loss of water and electrolytes which is most difficult to manage and, further, the skin becomes digested and inflamed. Children with an ileostomy may be nursed on their abdomen which allows the fluid to drain away from the skin. However, I do not like ileostomies because of the danger of fluid and electrolyte imbalance with resultant biochemical disturbances. Certainly a Mikulicz resection should not be used in upper small bowel obstructions.

My mortality of these cases is about fifty per cent. This baby is now doing well and having normal movements. I believe that this child is now cured.

I would like to stress that during an anastomosis in these cases, great care is of the utmost importance. The bowel is almost tissue-paper thin and holds sutures with great difficulty. In some cases I have been forced to do a one-layer silk anastomosis.

Dr. Ferguson:

I congratulate Dr. Clark on the successful outcome of the anastomosis performed on this little baby.

I should like to discuss several aspects of this interesting case. First of all, it was stressed that the obstruction was complete because no gas was visualized in the distal colon by X-ray. This finding is of significance only if the child has not received an enema previous to the X-ray examination. Frequently, babies with intestinal atresia are given enemas in the maternity hospital in the hope of overcoming some meconium plugging. At this time air may be introduced through the anus. Thus gas in the distal colon may be present in a baby with a high complete obstruction.

While discussing the differential diagnosis in this case Dr. Clark mentioned meconium ileus. That is a condition producing obstruction of the intestinal tract by plugging of the bowel with a thick "putty-like" meconium. It is invariably associated with pancreatic fibrosis. The deficiency of pancreatic enzymes in the intestinal tract produces a very thick sticky meconium which is incapable of passing through the gut. The X-ray film in such a case shows upper intestinal distention, and if the intestinal gas and the thick meconium have mixed, there is produced a typical ground-glass appearance to the film which is diagnostic of the condition.

Occasionally, a child with intestinal atresia will perforate his bowel during intrauterine life. The perforation usually seals over spontaneously and later, at laparotomy it may be difficult to determine the site of perforation. An X-ray film of the abdomen in such instances usually shows intraperitoneal calcification. This is known as meconium peritonitis. It should not be confused with meconium ileus which is an entirely different condition.

When the area of atresia is high in the intestinal tract, the surgeon must do a primary anastomosis. This is usually technically difficult due to the tremendous discrepancy in the size of the two loops of bowel. The proximal blind end may be huge, while the intestine distal to the area of atresia is usually very small, resembling a worm or a piece of spaghetti. Under such circumstances an end to end anastomosis is impossible and the procedure which must be done is a side to side anastomosis. As was done in this case, it is helpful to distend the distal bowel by injecting isotonic saline solution into the lumen. The saline flowing down through the distal bowel also eliminates the possibility of a second area of atresia. However, if the area of atresia is in the ileum or colon, one can quickly get the baby over this immediate difficulty by exteriorizing the atretic area and performing a Mikulicz double-barrelled enterostomy. Later the spur between the two segments of bowel may be crushed by a special clamp. It is then a comparatively simple matter to close the enterostomy at a second operation, at a time when the baby's condition is good. When exteriorizing bowel in infants, it is important that the bowel wall be sewn both to the peritoneum and to the skin. Otherwise either evisceration around the exteriorized bowel or retraction of the exteriorized bowel into the peritoneal cavity is apt to occur, with disastrous results. The ileostomy established in an atresia low down in the ileum does not often "run," so that there is usually no particular problem in meeting the fluid and electrolyte requirements of the infant.

Case No. 53-2416

This three-year-old male child had been perfectly well until one year prior to admission when he contracted measles. Shortly thereafter, the mother noticed that the child's abdomen began to enlarge, but he was otherwise well. About four months later puffiness was first noted around his eyes. Other than occasional headaches and insomnia his condition remained unchanged until two weeks prior to admission when, for the first time, swelling of the ankles was noted. There was no history of other previous illness. The family history was not pertinent.

Physical examination at time of admission revealed generalized edema. There was marked edema of the orbital fossa, moderate pitting edema of the legs, and a grossly distended abdomen with free fluid. His weight was 45 lbs.; the blood pressure 150/85.

Laboratory investigations were carried out as follows: Urine: Volume, 125 c.c. per 24 hours; 2 gm. % albumin, 30-40 erythrocytes per high powered field, specific gravity 1.037, pH. 6.0. The hemoglobin was 10.8 gm., leucocyte count 8.900, sedimentation rate 131 mm. per hour (Westergren). The blood urea nitrogen was 40.2 mgm. %, the serum proteins total 3.3 gm. %, albumin 1.32 gm. %, globulin 2.01 gm. %. The serum sodium was 140 m.Eq. per litre, the serum chloride 101 m.Eq. per litre and the serum cholesterol 341 mgm. % (Esters—264 mgm. %).

The patient was placed on a low sodium diet and penicillin was administered in prophylactic doses twice a day. Fifteen mgm. of ACTH was given every eight hours for ten days by the intramuscular route. There was little change in the findings until the seventh day of treatment, when the albuminuria diminished, the urine

volume increased and his weight began to fall. By the tenth day his urine was free from albumin, and he had lost 8 lbs. The ACTH was then discontinued. However, five days after the withdrawal of ACTH his urine output began to decrease, the albuminuria and the hematuria recurred, and his weight increased. A second course of ACTH was begun. This time the dosage was 10 mgm. every eight hours. As in the first instance his urine became free from albumin on the seventh day but this time there was a much less marked diuresis and loss of weight. At the present time, after seventeen days of treatment his weight is 39 lbs. and there is minimal peripheral edema. The total serum protein is 5.7 gm. %, albumin is 3.5 gm. % and globulin 2.2 gm. %. The blood urea nitrogen is 21 mgm. % and the serum cholesterol is 148 mgm. %.

Dr. Israels:

The Nephrotic Syndrome is a gypsy amongst the diseases. For while it is recognized as possibly being a disease entity in children, the internists deny that this is true and classify it as a stage of nephritis. As in any syndrome the etiology is varied; it may result from heavy metal poison, it may represent a stage of glomerular nephritis, it may be produced by amyloidosis, it may result from thrombosis of the renal vein, or finally, it may be a manifestation of a disease entity known as lipoid nephrosis. Lipoid nephrosis is characterized by edema, albuminuria, hypercholesterolemia and the absence of hypertension. In the present case the hematuria, the raised blood urea and the hypertension tend to place the child in the category of a nephrotic syndrome secondary to chronic or sub-acute glomerulonephritis.

The cause of edema has been the subject of some discussion. It is usually thought that the hypoproteinemia allows water to leave the vascular space and that the hypoproteinemia is produced by protein loss via the kidney. However, the edema at times disappears entirely in a spontaneous remission and yet the plasma protein levels remain exactly the same as they were during the height of the edema. This raises the possibility that the plasma protein may be abnormal in their composition therefore allowing the kidney to throw them out. This hypothesis has been explored and it has been shown by immunological methods that the plasma proteins are identical with the urinary proteins. On this basis it would appear that a nephrosis with hypoproteinemia is of nutritional origin. As a matter of fact, there was at one time an argument whether this disease was primarily one of the kidney or whether it was a general systemic disease with faulty production of plasma protein. Pathological studies have been of very little help in deciding whether the above is correct, for the lesions in the kidney do not adequately explain the cause of the albuminuria.

In our experience the prognosis in lipoid nephrosis is not good. This is in contrast with the results reported by Dr. Janeway in Boston who reported a remarkable number of cures even prior to the present methods of therapy. The prognosis is universally bad when it represents a stage of glomerulonephritis.

Therapy of this syndrome has varied from time to time and good results have been claimed for each new treatment. Dr. Janeway has emphasized the importance of protecting these children from infection. He suggested that hospitalization was most undesirable because of the intimate contacts with other children from whom he may get an infection. He therefore advised that these children be treated at home, and further, that on the onset of any infection vigorous antibiotic treatment be instituted.

However, the most obvious manifestation of this syndrome is the edema. Therefore pediatricians and internists have been obsessed with the idea of relieving the edema immediately, even though some of the children who are markedly edematous show no impairment in activity and feel subjectively well. Amongst the measures which have been used to relieve the edema are various types of diuretics, plasma expanders such as gum acacia and salt-free albumin. All of these have resulted in some temporary success but the edema has rapidly recurred. During the 1940's it was observed that following an attack of measles a remission of some duration frequently occurred in these children. For a time pediatricians exposed cases of nephrosis to measles with the hope of producing such a remission. Similar remissions have been recorded in edematous nephrotics following infection with Malaria. Because of the hypercholesterolemia, a situation also obtaining in hypothyroidism, many patients have been treated with thyroid hormone, but this type of therapy has now fallen into disrepute.

More recently the hormones ACTH and Cortisone have become available. It was inevitable that they be tried in the treatment of nephrosis. Results to date have shown that in about 80% of cases either ACTH or Cortisone in adequate doses will produce a diuresis and a remission of the disease which may last for weeks or even months. This remission is characterized not only by a reduction in edema, but also a rise in plasma proteins, diminution or cessation of proteinuria and a return to normal levels of the blood cholesterol.

It is my opinion that these hormones are the best methods presently available for obtaining a remission in this syndrome. Whether a "cure" is obtained, only time will tell, as these therapeutic measures have only become available relatively recently. It has not yet been settled whether treatment should be continuous or intermittent.

Neither is it clear which of these hormones is the drug of choice. However, the fact that Cortisone may be given orally appears to make it preferable at the moment. I would favour its use continuously in order to maintain the child in remission.

Dr. Read:

In 1922 Newburgh demonstrated that the integrity of the extracellular fluid depended upon the ion sodium. It therefore follows that any extension of the extra-cellular space such as is found in the nephrotic syndrome must be associated with sodium retention. Yet the reason why these patients do retain sodium is, unfortunately, unknown. Most early cases of lipoid nephrosis show a diminished glomerular filtration rate (G.F.R.) which results in a diminished amount of filtrate passing down the renal tubule. This may allow increased reabsorption of sodium to occur. Another factor may be that these patients produce an increased amount of DOCA-like hormone by their adrenal glands, but as yet the evidence in favour of this is far from conclusive. It has naturally been suggested that anti-diuretic hormone (ADH) excess is the cause of the edema. However, studies in which this hormone has been measured have usually suffered from an inadequate assay method. Those in which such a criticism cannot be levelled have not to my knowledge demonstrated any increased excretion of anti-diuretic hormone. Crawford and his associates have found that the nephrotic individual responds to a water load with a diuresis in the same way that a normal individual does and that this is associated with a decreased amount of ADH in the urine. He has also shown that the nephrotic individual who is given a salt load first of all retains the salt later has a salt diuresis just as the normal person does.

Although the osmotic pressure which results from the presence of plasma protein in the vascular spaces is very important in the partition of extracellular fluid between the vascular and interstitial compartments, the edema that the nephrotic has is not due to the decreased amount of plasma proteins found in this syndrome. That this is true is evident for in either induced or spontaneous remissions the diuresis occurs several days before there is any change in the plasma protein level.

I would like to remind you that there is an important difference between intramuscularly administered Cortisone and orally administered Cortisone. Of course the hormone causes atrophy of the adrenal cortex by either route by means of suppressing the ACTH production of the pituitary. However, when Cortisone is given intramuscularly the full effect of the dose is not obtained for eighteen to thirty-six hours later. Similarly, on withdrawal of the drug, its effect lingers on for sometime. In contrast to this, the maximum effect of orally administered Cortisone is within six hours of administration, and it is entirely over in twelve hours. Therefore oral Cortisone should be administered every six hours throughout the day. Also, when it is withdrawn, it should be gradually cut down, otherwise the patient will be thrown on his own resources. His adrenal glands, being now hypoplastic, may be inadequate for his purposes, so that an acute Addisonian crisis may follow.

It is interesting that Cortisone which when given to a normal individual causes a mild sodium retention should cause a sodium diuresis in the nephrotic. Dr. J. S. L. Browne has commented on this, pointing out that the body's reactions to Cortisone seem to depend on the metabolic and physiologic state of the body at the time. Under one condition it may cause a sodium retention; under another condition it may cause a sodium diuresis.

Manitoba Medical Association

Presidential Address

Delivered at the Annual Meeting of the Manitoba Medical Association, October 16th, 1953, by Dr. C. W. Wiebe, Retiring President

During my term as President of the Manitoba Division of the Canadian Medical Association I have been assigned a number of duties. This evening, the time has arrived for me to fulfill another duty as President of our Association. I am referring to the President's Address, which is to be delivered, according to our constitution, at the Annual Business Meeting of the Association. I must confess that this is not the most pleasurable task I have been requested to perform; but if you will bear with me for a short while, I shall complete this duty of my office.

Before proceeding with the main subject of my speech, I wish to take this opportunity to thank you for the honour which you conferred upon me by electing me your President. I have endeavoured to carry out my duties to the best of my ability and trust that my actions have met with your approval. However, the President of an organization such as this is merely the figure-head around which the organization functions. It is the executive body and the members of the Association who do the real work and it is upon them that its strength and successful function depends. During the past year, all members of the Executive have worked hard and faithfully in the fulfilment of their obligations, and all members of the Association, who have been called upon to perform special duties, have given willingly of their time and performed their tasks to the best of their ability. To the members of the Executive of the Manitoba Medical Association, to the members of special committees which functioned during the year, and to the members of the various committees responsible for the organization of the Canadian Medical Association's Annual Convention held in Winnipeg last spring, I extend my heart-felt thanks for the splendid support which you have given me and for a job well done. All those associated with the organization of the Convention are to be especially congratulated for giving so unselfishly of their time and effort.

The subject I have chosen for this evening is "Private Practice in Relation to Voluntary and Governmental Agencies Administering Medical Care." In Manitoba, as well as in the other provinces of Canada, the institution known as the private practice of medicine is traditional as the means by which the independent individual obtains medical care when he is ill. It is further traditional that the patient, if able, pays for this service on a fee-for-service basis. The person who renders the service is usually the family physician or his consultant.

Since the turn of the century private practice has undergone a marked degree of change. Comparatively speaking, the early physician possessed a limited knowledge of the medical sciences, a condition which made the practice of medicine at that time, somewhat empirical. There are, to be sure, certain aspects of medical practice which have not displayed any significant degree of change. The fact remains, however, that our increased knowledge of the basic sciences has provided us with a better understanding of medicine, and thereby widened the field of practice. We are, for example, indebted to research in the science of bacteriology for our knowledge of many diseases caused by bacteria and viruses. From this source also surgery received the aseptic scalpel, while medicine has been provided with a host of weapons against communicable diseases.

The contributions made by the various sciences to the field of medicine are too numerous to mention at this time. Suffice it to say that they have all supplemented the physician's knowledge of diseases and widened his sphere of practice. The ensuing result is quite in evidence throughout our profession today; namely the trend towards more specialization. A specialization has, we must admit, contributed much to the advancement of medicine. But it has also tended to narrow the interest of the doctor to the organ or part affected by the disease. The development of psychiatry and psychosomatic medicine during the past two decades, has done much to renew insistence on the fact that the individual human being must never be lost sight of during diagnosis and treatment of disease. Psychosomatic may be interpreted as the attitude of the early family physician; an attitude prevalent before the term psychosomatic was coined. I quote Dr. Louis Hamman in this regard: "It is an attitude or leaven that gradually will permeate and quicken the whole of medical practice. It is the human element in practice that focuses attention upon patient as a person, and puts his problems and needs above the mere consideration of disease."

Changes have also occurred in the physical setup. The modern physician has a better workshop, equipped with modern diagnostic facilities, staffed with nurse and receptionist. He is frequently found in partnership with one or more associates. Many urban and rural practitioners are sharing these facilities and reaping the benefits of consultation and specialization. A close association with his professional colleagues also

provides the impetus and the opportunity to attend post-graduate courses. The latter enable the individual to keep abreast of new developments in medicine.

Today, generally speaking, the patient comes to the doctor and not the doctor to the patient. A patient is seldom seen in his or her home environment. In sharp contrast we recall the earlier physician who had an intimate knowledge of every patient's family life and social and economic status. Nowadays, a patient who visits a clinic or doctor's office may see a receptionist, a nurse, a technician and perhaps a consultant and/or the family physician. They are all very efficient to be sure, each examining a different part of the body, but at times little conscious of the anxiety which caused the symptoms and disease. With the present development of medical care we are fast approaching the day when social case-workers will be necessary to assist in ascertaining the social components of illness.

Concurrent with the changes in medical care there have come into existence "medical lay" organizations. I am referring to the voluntary or governmental agencies administering medical care to persons who are unable to purchase it themselves. Agencies of this type also assist persons who suffer from certain diseases which are a threat to the health and well-being of other people. These organizations have progressed beyond their original attempts to deal with the more obvious epidemic diseases and with the care of the destitute. As scientific study revealed more and more the causes of illness and disability, people began to contemplate the possibilities of attaining higher standards of well being. The action which followed such contemplation has resulted in the organization of programme after programme; the Cancer Relief Research Institute being one such organization, while the Manitoba Sanatorium Board organized by the late D. A. Stewart is another. The latter group proved to be one of the early voluntary agencies of its kind in Manitoba. During the period following its inception many members of the profession were quite skeptical of it, and few showed any enthusiasm for its programme. Since then, however, the excellent record of service accredited to this body, has afforded it a favourable reception in all medical circles. Relatively recent developments, such as the construction of more rural hospitals, the formation of health districts plus the introduction of routine chest plates have returned to the general practitioner the detection and prevention of tuberculosis.

In some programmes the emphasis is mainly on rehabilitation as for example: The Canadian Arthritis and Rheumatism Society (Manitoba Division), the Canadian Paraplegic Association, the Crippled Children Society of Manitoba, the Multiple Sclerosis Society, the Canadian Heart Association. Some are designed to help certain age groups or groups subjected to special hazards, such as infants, mothers, school children, industrial workers. Still others play a part in the education of communities as to the possibilities of better health. Our governmental agencies have been largely responsible for this.

In all these programmes there is emphasis on prevention and control of diseases; but none can be entirely divorced from diagnosis and treatment. When our Provincial Government passed the Health Services Act in 1945 the Association was somewhat disturbed about the provision of X-ray and laboratory facilities, then called diagnostic units. It was considered an encroachment on private practice. Since that date almost every rural hospital is using these facilities and the cost is partly carried by local and provincial governments. The cost of all medical care given by governmental agencies, both Provincial and Dominion, is diffused wholly or partly over all members of society by means of taxes. The cost of medical care given by voluntary agencies is diffused wholly or partly over all members of society through taxes and voluntary donations. Physicians who perform medical service for governmental agencies usually receive remuneration on a salary basis. Physicians who perform medical service for the voluntary agencies normally receive remuneration in the form of an "honorarium." Many private practitioners are partly employed by either, or in some cases, by both agencies. A practitioner falling in this category will receive income from the agencies in question and from his private practice.

The kind of medical care given by physicians when employed by these agencies is in many cases identical with that given in their private practice. Consequently, one reaches the conclusion that the actions of certain members of the profession are extremely inconsistent; unless, of course, they are only giving lip service to the principle of fee-for-service. One encounters a similar problem when attempting to find any consistency in the actions of governmental agencies, agencies which compete openly with private practice in the provision of medical care.

Our Association champions the cause of private practice. It desires to make adequate medical care available to all members of society. In the past and at present it has proven this by giving service unstintingly to indigents and underprivileged. As to the future, your Association advocates a voluntary prepayment plan which will distribute the cost of medical care over all members of society. It will require the "best brains" of the profession and the loyalty of all members of our Association to eliminate the imperfections still present in our plan.

I am confident, however, that with the co-operation of all members of the Association we shall accomplish this task. Indeed it is imperative that we do, for the future of our plan is closely related to the future of that tradition I spoke of earlier—the tradition of private practice.

Toast to the Council

Delivered at the Annual Meeting of the Manitoba Medical Association, October, 1953, by Dr. W. F. Tisdale, President Elect

I have been honoured by our president by being asked to propose the toast to our guests, the Council, and our parent body the C.M.A.

It has almost become a habit for a speaker to be intimidated into promising to be brief. However, I warn you that I may be like the little girl who, when asked by her teacher if she could spell banana, answered "Yes, I can, but sometimes when I get started, I don't know when to stop." However, a more logical lesson in the virtue of brevity might be drawn from a man of our own profession, a great Edinburgh surgeon, Syme, father-in-law to Lister. Of him it was said that he never wasted a word, never wasted a drop of ink, and never wasted a drop of his patients' blood.

This meeting consists of two parts. First—the meeting of the executive followed two days later by the Council whose duty it is to discuss and give direction to the Association on their business affairs and their policy for the future.

We still have our problems to solve—even so common-place a one as making a living. We worry over the time it takes for a student to get a full medical training, but the problem is not new. Reading the life of John Hunter not long ago, I was struck by his statement that "by the time a doctor could afford to buy bread, he had no teeth left with which to eat it." Now the course is no shorter, but our nutrition and dentistry have improved.

Tonight we are giving a well earned reward to this group. Tomorrow morning we begin the scientific session, the part that Osler described as the yearly brain dusting for the profession which he thought so necessary.

Tell it not in Gath. Publish it not in the streets of Askelon, but these were his words; "No class of men needs criticism so much as physicians, no class gets less. The busy round of a practitioner tends to develop an egoism of the most intense kind to which there is no antidote. The few set-backs are forgotten, the mistakes are often buried, and ten years success only makes a man touchy, dogmatic, intolerant of correction and abominably self-centred. To this mental attitude the medical society is the best corrective, and a man misses a good part of his education who does not get knocked about a bit by his colleagues in discussion and criticism." A well known quotation from Cowper might be often repeated to us. "Knowledge is proud that he has learned so much, Wisdom is humble that he knows no more."

Now this may sound a bit serious to the ladies, so let me show you a more human side of Osler as told by his wife. "As a patient he behaved very badly; would not have his window open; refused to be nursed; twisted his coverlets up; refused to have his bed made; wished only to turn his face to the wall and be sick in peace." Did you ever see a man like that?

To our Executive and Council our Association looks for wise guidance. There are two ways to progress—one by revolution where tremendous upheavals occur and great changes are imposed at once. To the medical man this would mean being dragged as a reluctant captive along a road of another's choosing. Rather let us lead the way in our own profession. Our duty is simple. It is to give to our fellow man protection against illness and make an intelligent attempt to restore health from illness. Let us then choose the method laid down by nature—the oldest, greatest teacher—the method of evolution, that most cautious but most successful method of all. Looking at the past we see a glorious procession of events that have lifted many fears and dangers from our people. But evolution is relentless in its demand for progress and we must plan greater things for the future.

Progress does not take the form of a steady ascent. Rather it resembles a stair where there is rest to consolidate an epoch, or it may be likened to the undulations of great ocean waves. Now we are riding a new wave of progress, probably near its crest, and from that eminence we should see a farther horizon than man has ever seen. And let us not be unduly proud, for this is not all of our own doing. Rather we are pigmies lifted on the shoulders of giants. These great benefactors, to mention only a few, are the scientists and industrialists who have given us so much; the metallurgists who have given us Vitallium, that marvellous metal which lives so peacefully with human tissue and has given so rich a benefaction to orthopaedic surgery; the scientists who have given us chemotherapy and the wonderful advances of modern anaesthetics. Only one of outstanding merit may we claim for our own—that of Dr. Fleming who discovered the key that unlocked the door to the magic of the antibiotics.

Let us then set our hope on none other than that new goal, and may that goal be better medical service for our Nation than it has ever known before. May the aim of our Association be to read the future aright and to point the way and prepare the plans, maybe at some sacrifice to ourselves but never at the sacrifice of the efficiency or ideals of our profession.

To our guests, the Council, the parliament of our Association, we look for leadership with hope and with confidence.

Ladies and gentlemen, the Canadian Medical Association.

Winnipeg Medical Society

Reported by R. H. McFarlane

The regular monthly meeting of the Society was held at the Medical College on Friday, 23rd October, 1953.

One of the main items of business was a notice of motion presented by Dr. G. F. Allison, to be voted on at a future meeting of the Society. The motion, which would do away with the reading, at the Annual Meeting, of all the committee and section reports, would call for these to be circulated beforehand to the members. Discussion of interesting or controversial reports could be had at the Annual Meeting. If carried, this motion will have the effect of materially shortening and livening up the Annual Meeting, and in the writer's opinion is an excellent idea.

The program for the evening consisted of a four-part symposium on poliomyelitis. Dr. J. D. Adamson spoke on the epidemiology of the disease, Dr. R. T. Ross on diagnosis, Dr. J. A. Hildes on certain aspects of treatment, and Dr. M. H. Desmarais on the application of physical methods of treatment.

Dr. Adamson outlined the history of epidemics occurring in Manitoba, mentioning that the earliest cases he knew of had happened in 1916 or 1918 and that adequate records had been kept only since 1928. The numbers and age incidences involved in each epidemic were shown on lantern slides. Two new facets of the disease appeared in the present epidemic: (a) its occurrence only one year after another serious epidemic and (b) the increasing numbers of adults attacked by the disease. He concluded that the appearance of the disease and its distribution depended on a number of factors such as the number of susceptible individuals, hygienic circumstances and in this area as well, heat and humidity.

When asked his prediction for next year, Dr. Adamson said he thought there would not be another epidemic, but also noted that he had made a similar prediction the year before.

Dr. Ross, speaking on the subject of diagnosis gave a concisely detailed account of the course of the disease, including descriptions of a prodromal phase of two or three days duration, occurring six to eight days before the main attack occurred. He mentioned that this might occur in only 40% of cases and that at this time the spinal fluid would be uniformly negative. Next followed a description of a pre-paralytic phase, of 6-8 days' duration with fever, stiff neck and back and spasm of muscles; the spinal fluid showing a cellular response in 100% of cases at this time. This stage ends in paralysis occurring or else in the spontaneous subsidence of symptoms. Dr. Ross then proceeded to a description of the onset of bulbar paralysis and the difficulties involved in the diagnosis of polio-encephalitis.

Dr. Hildes noted that about 15% of hospital admissions and 10% of all cases showed some degree of respiratory paralysis or difficulty. This might occur from paralysis of intercostal muscles, obstruction to the airway from inability to clear the throat of secretions, or from disease of the respiratory centre itself. He pointed out that respiratory embarrassment could occur rapidly or insidiously and mentioned a vital capacity of one litre or less as being one indication for the use of a respirator. He mentioned the advantages of the tank type respirator over such other methods of artificial respiration as positive pressure breathing masks, rocking beds and so on, and emphasized the great difficulty of caring for patients in respirators.

Dr. Desmarais mentioned some of the more common deformities which occurred and noted particularly the difficulties encountered in children whose growing bones and joints could be quite seriously and permanently deformed. He noted especially the value of prolonged supervision and exercises to maintain and correct postural defects resulting from unopposed muscle pull.

There was a good deal of discussion of each of the four papers, but the last one seemed to draw some fire from some of the orthopedic surgeons present, although, when the smoke had cleared, one was left with a reasonably good impression of the type of program Dr. Desmarais had outlined.

At the last meeting of Council, Dr. J. T. Downey was appointed Chairman of the Medical Defense Committee, replacing Dr. A. R. Tanner. Dr. Tanner will, however, remain on the Committee.

Editorial

J. C. Hossack, M.D., C.M. (Man.), Editor

Merry Christmas

No other day in all the year is quite like Christmas Day. There are other anniversaries which we enjoy alone or share with a few or even with many. But Christmas is different. Somehow it stands out as does no other day. Somehow it is easier to go backward through the years by thinking of how we spent each Christmas in the past. And though each revives its happy memories there is a touch of sadness as we think of broken circles, for never more than on Christmas Day do we feel how heavy are the years.

Christmas is so much a children's day that, as we grow older, we more and more retreat from the centre of the festival. And, because we are older and less touched by its magic, we feel that it was a better and happier time in our own childhood. Christmas Past was a quiet event. Snow muted the sound of horse's hooves and the jingling sleigh bells, ringing merrily and heard so often, livened the air. And in the evenings little bands would appear and break the silence with their childish trebles; and the flakes of snow would fall more gently and more slowly as if afraid to miss the singing or mar it by their motion.

We miss these tiny choristers whose little voices are surely of all sounds most fitting for such a season. Now we must suffer a barrage of noise. Good King Wenceslas, disentombed for a fortnight, is paraded hourly until everyone is heartily sick of him; and he himself, were he capable of hearing, would wish to goodness that he had done something else—taken a nap, for example—on that night of Stephen. Twenty times a day for almost as many days, the faithful are summoned to Bethlehem, and gentlemen are hailed with "rest ye merry" and nights that might be peaceful are disturbed by blarings of "Silent Night."

Seeing that the purpose of this plethora of carols is the loosening of purse-strings, the whole thing verges on blasphemy. Christmas is no longer the day on which simple, hopeful folks meditate upon the Miracle of Bethlehem, and dwell upon the possibility of those other miracles—Peace on Earth and Goodwill Among Men. Now it is a time for filling shops with people whose faces show that what they are about is a duty rather than a pleasure.

But to the children the day is still the same. And if it has been spoiled for the oldsters it still is full of happiness for the youngsters. And we, however old, can enjoy it also if we will but throw aside the years and silence the radio and hang up our stockings beside those of our grandchildren and with them "O-o-o-o" and "A-a-a-a" as we open our parcels.

It is the children's day for its Founder was a child. And it is a kindly, forgiving day, even as was its Founder kindly and forgiving. And it is a day when, like the sunshine breaking through the clouds, Peace, Charity and Goodwill for a little while light up the land and show how beautiful it would be if men would only honour Christmas in their hearts and try to keep it all the year. Merry Christmas!

Large Hospitals and Small Ones

If it be true that the Russians desire only peace, and if it be true that their fact-finding planes have crossed our borders, then the report they have had on Winnipeg must be most comforting. "For," they would say in the Kremlin, "if these people had war in their minds they certainly would not congregate so many sick into so few buildings. Two small bombs," they would continue, "would put out of business nearly all their hospital facilities, and even if the buildings went untouched a very few small bombs could render them inaccessible." "Therefore," they would conclude, "Canada, as represented by Winnipeg, has no thought of war."

On the other hand if the Russians plan to destroy us, the situation would be equally pleasing It might distress them to see large industrial plants dissolving into small scattered units for greater safety; but, so long as casualties can be denied help, the situation from their standpoint, would not be unsatisfactory.

Disaster quickly would be our lot should we be attacked; but the concentration of hospital facilities has disadvantages in time of peace as well as in time of war. Accidents and emergencies of many sorts occur daily in all parts of a large metropolitan area. Comfort certainly, and life very often, will depend on prompt attention. Abundant equipment won't help if it is not available. Simple apparatus and moderate skill at the time is what is needed.

In great cities small hospitals are equally necessary with large ones—more necessary in fact because a place for highly specialized treatment need not be large. But as a city stretches farther and farther from its centre and spreads in every direction, suburban hospitals become more necessary. Their convenience is great both to patients who wish to remain near to their friends and to the doctors who live near by.

A generation or less ago most patients were treated at home. Even operations were done successfully and home confinements were the rule. Now scarcely anything is done at home but there should be no need to move a patient several miles to a town-in-a-building. The majority of illnesses can be treated successfully with the equipment and by the staff that one expects to find in a small institution. The injured and the desperately ill cannot afford the time consumed or the damage that may be inflicted by a long ambulance ride.

The ideal arrangement for hospitals is not one or two immense buildings inhabited by thousands but one or two moderately large establishments with several satellites. The large ones would supply what the smaller ones lack in apparatus and staff. The small hospital can furnish an atmosphere impossible in a large one. To be one thousandth of the population makes one feel almost lost. In a small hospital it is possible for a patient to be a person with a name. In a very large hospital it is almost inevitable that he become a case with a number.

The smaller staff makes it easy for all to know each other and to take a more personal interest in the institution as a whole as well as in its inmates. There are, moreover, advantages to the doctors who attend, for each has a more active say in hospital affairs and a greater incentive to exert himself in the hospital's interests.

The larger establishments would house equipment and furnishing beyond the scope of the smaller ones.

Now all this may sound very pointless. The fact is that great enlargements are being planned or being completed. And another fact is the recent closing of a small community hospital. But it does not follow that hospital building is at an end, and the desirability of small local hospitals, already evident, will continue to become more so as growing suburbs swell in population and retreat even farther from the centre of the city.

Perhaps the fears of our pessimistic neighbours to the south may not be justified. Let us hope so for, as it stands now, we are terribly vulnerable when it comes to hospital care.

Letter to the Editor

Re: Specialist Register

The Review has at various times published an application form to be completed and submitted, accompanied by a fee of five dollars, by those wishing to be classified as specialists and have their names appear in the proposed Register. It is to oppose setting up such a Register that I am moved to write this letter, hoping that there will be sufficient others who agree with me to have the matter rescinded and dropped. I might add that a copy is going to the C.P. & S. to keep the records straight.

The M.M.A. office evidently finds itself in an embarrassing situation at times when someone telephones asking to name a specialist whom he or she may consult. The M.M.A. having no Register of specialists cannot therefore supply such information. It is proposed that the above Register will overcome this difficulty. What seems completely incomprehensible is the fact that the M.M.A. could obtain this information by merely copying down the names of specialists practicing in Manitoba from the Royal College Register of duly accredited doctors at no cost whatsoever.

This, however, is not satisfactory to the C.P. & S. There are doctors who have done post graduate work and are limiting their practices but are not accredited by the Royal College. If the C.P. & S. adjudges these as being satisfactorily qualified their names will be included in the Register. They feel that such doctors should not be asked to write even Certification examinations to be accredited. The obvious result of this will be two standards of classification in Manitoba. The Royal College accreditation will be accepted but additionally there will be the accreditation by the C.P. & S.

Little thought seems to have been given to the effect that such accreditation will have on those obtaining, shall we say, sub-standard accreditation. I can well foresee the difficulty that such a person will have in trying to obtain an Active Attending Staff appointment in one of the Teaching hospitals and beyond that a Teaching appointment with the Medical Faculty. If the Fellowship accreditation were the only standard, a measure of leniency might be justified, but anyone practising a specialty should surely be able to pass the Certification examinations. To add yet another, and a lower standard, I feel is out of place.

Somehow the five dollar fee irks me no end. If the C.P. & S. deems such a Register necessary, surely it has enough money in its coffers that it can well finance such a scheme. But then it is felt that this would be an imposition on the disinterested general practitioner, with which I agree. But what about the Specialist? It seems to be quite fair to impose this fee on him despite the fact that he has had no voice in the proposed Register. Also the fee strikes me as being a form of coercion in that if it does not accompany the application, said application cannot be approved. And whatever the import of the Register the fee would stand in the way of a person being

accredited by the C.P. & S. and all its implications. More than that the specialist has no need of the Register and it should suffice that if he desire a copy that he be permitted to purchase it, but not deny his name appearing for lack of the fee. I feel that this principle is wrong and undemocratic.

Also, in speaking with no less than four duly accredited specialists chosen at random, not one of them had heard of the Specialist Register, and comes the deadline, January 1st, 1954, the C.P. & S. will, possibly quite unintentionally, find that a considerable number of duly accredited specialists will be missing from the list of applicants. To my knowledge no personal contact has been made and allowances will have to be made for having missed the application form in the Review.

I would not by this letter detract from the efforts of the members of the executive of the C.P. & S., since I know that they are working in our common interests. If I am in error in some of my statements, the error is unintentional, and I stand to be corrected. But in a general way I feel that my arguments are valid and I sincerely hope that the C.P. & S. will give the matter due consideration.

Yours sincerely,

H. Funk, M.D.

P.S.—I am credibly informed that personal communications were sent out so that argument does not apply. The fact still remains that a number of specialists are not now aware of it which I believe is significant.

Special Contributions II
Our Dentists

Our sister profession of Dentistry has always worked in close association with the Doctors of Medicine on problems in their particular field.

For a number of years some of the more progressive members of the dental profession have been trying to get a Dental College started in the Province. Their efforts have so far gone unrewarded. In due time a Dental College will be established because the need is great. The medical profession has given them full support and no doubt will continue to do so.

Fluoridation of water to prevent caries in childhood has been recommended by the dental profession and endorsed by the medical profession on the basis of research and studies in many cities, both in Canada and the United States. At the present time there is a very vocal body of citizens opposed to this procedure—but with patience this also may be achieved.

The problem of the moment affecting our two professions concerns admission of patients to hospitals for dental surgery when these patients are on Manitoba Hospital Service Association. In order to qualify for admission a doctor has to sign a certificate to the effect that:

1. "The patient has a systemic condition making hospitalization necessary for dental care."

2. "The patient requires multiple mouth extraction, or has impacted tooth, involving resection of the gum, which might lead to psychological or systemic reaction which would require hospitalization."

3. "The patient has a severe oral infection requiring hospital care and medical consultation."

Legal opinion was obtained on this matter to the effect that:

1. "The doctor is simply signing a statement of fact as to the patient's need for admission and as long as this is a true statement, made in accordance with the doctor's own knowledge of the patient's condition and not on hearsay evidence, he need have no fear of the consequences."

2. "If the dentist is a fully licensed dental practitioner and as long as the doctor agrees that the treatment is required, having seen the patient himself, he should have to assume no more responsibility than if he had called in a consultant in urology or any other specialty to carry out a special procedure on his patient."

This statement seemed to make the physician's position clear in regard to signing the forms of the Manitoba Hospital Service Association.

October 1, 1953.

L. A. SIGURDSON.

The Northwest District Medical Society

A meeting of the Northwest District Medical Society was held at Virden on Thursday, Oct. 1st.

At 5 o'clock the party toured the oil fields of the California Standard under the direction of Mr. Johnson and visited the pumping station of the International Pipe Line at Cromer.

Dinner was served at the Central Hotel when approximately 30 persons were present including Mrs. G. R. Clingan, widow of the late Dr. George R. Clingan, and Mrs. Coleman, matron of the Virden Hospital.

The scientific programme was held in the spacious surroundings of the new Virden Clinic Building. Present were: :

Dr. J. E. Hudson, Hamiota, Chairman
Dr. S. E. Bjornson, Miniota
Dr. D. L. Bradley, Reston
Dr. D. L. Bruce, Elkhorn
Dr. J. A. Dupont, Virden
Dr. A. J. Elliott, Oak River
Dr. W. A. Gorrie, Virden
Dr. W. K. Hames, Kenton
Dr. R. S. Harris, Virden
Dr. D. L. Kippen, Winnipeg
Dr. M. T. Macfarland, Winnipeg
Dr. J. R. Monteith, Virden
Dr. W. J. Sharman, Clanwilliam
Dr. M. R. Sirrett, Erickson
Dr. C. W. Wiebe, Winkler

Dr. Hudson outlined the difficulties which had existed of having meetings at a time and place which would ensure a satisfactory turnout of members but, after considerable discussion, it was agreed to alternate the meetings between the northern and southern boundaries of the District; also, that an invitation might be extended to neighboring districts.

Dr. C. W. Wiebe, President of the Manitoba Medical Association, was introduced and reviewed some of the highlights of the year's work including the opening of the Manitoba Medical Service Building, the successful meeting of the Canadian Medical Association in Winnipeg during June, the work of the District Medical Societies and of the various committees of the Association, including that of revision of the minimum schedule of fees by the Fee Committee. Dr. Wiebe invited all members to attend the Annual Business Session on Oct. 16th.

In commenting on the extensive work involved in a revision of the minimum fee schedule, Dr. M. T. Macfarland produced a copy of the schedule prepared about 1922 by the Northwest District Society in which the procedures were less numerous but comparable in many ways with the current schedule.

Dr. D. L. Kippen of Winnipeg spoke on the subject "Organic and Functional Diseases of the Upper Gastro-Intestinal Tract" and a lively discussion followed.

Refreshments were served by the Clinic Staff.

M. T. M.

Book Reviews

Modern Treatment—a Guide for General Practice is a very large book which might properly be described as an encyclopedia of treatment. It covers all physiological systems and includes all non-surgical techniques. Practically every help a practitioner may need is given to him. The diseases and disorders of every period from infancy to senility are discussed. "Accidents by flood and fire and i' the immanent deadly breach" find a place: at least methods for stimulating respiration, for the treatment of burns and shock all are given longer or shorter attention. The Index (2,500 references) begins with abdominal distention and ends with Ziram which is a fungicide I hadn't heard about before. If the answer to the therapeutic problem is not to be found somewhere in these 1146 pages, that answer has not yet been found.

The book contains much more than mere details of treatment. Chapters which should prove exceedingly helpful are on Patient-Physician Relationship; Pharmacological Principles in Treatment; Principles of Clinical Immunology; Water and Electrolyte Balance; Psychosomatic Principles in Treatment; Treatment in Obstetrics (not the management of labour, of course). These are not all of the illuminating special chapters.

There are chapters on Diagnostic Technics "which the practicing physician must know and put to use." These include such things as Circulation Times; Tests for Hypertension; for Venous Insufficiency; Renal Function; Liver Function and so on. Diagnostic and Therapeutic Radiology; Physical Therapy; Geriatrics; Surgical Principles in Treatment are other chapter headings.

The fifty-three collaborators all address themselves to the practitioner and, between them, have produced a volume so comprehensive that the owner of it will have little occasion to look elsewhere.

Modern Treatment: A Guide for General Practice, by fifty-three authors. Edited by Austin Smith, M.D., Editor of the Journal American Medical Association, and Paul L. Werner, M.D., Secretary, Committee on Research, A.M.A. Published by Paul B. Hoeber Inc., Ryerson Press, 299 Queen Street West, Toronto, Ont. Price $22.00. (Will be sent on approval).

The Conception of Disease, by Walter Riese, discusses the various concepts of disease which have succeeded each other since ancient times. Each concept has been linked with, and influenced by, the circumstances of its time. In every period the explanations for the phenomena of disease have invariably been coloured by the philosophical ideas then current. This is natural seeing that originally medicine was but a branch of philosophy.

But a concept once established was never completely displaced. To a greater or less degree each has persisted even if in altered or attenuated form. Magic, the oldest of all philosophies, is not yet dead for many still see in it a cause of disease and a means of cure.

This book sets forth the principle concepts that have held the stage. Beginning with the Stoic concept there follow the Platonic, the Anthropologic, the Moral, the Hippocratic (physicological) the Anatomical, the Etiological, the Psychological, the Metaphysical concepts.

Concepts come from the minds of men such as make discoveries or found schools. In this presentation we see the influences that play upon, and are exerted by, men such as Hippocrates, Vesalius, Virchow, Freud, among others.

This book serves a useful purpose and makes instructive reading. The author is attached to the University of West Virginia and holds a number of other appointments.

The Conception of Disease, by Walter Riese, M.D. The Philosophical Library, 15 East 40th Street, New York, 16, N.Y. 120 pages. Price $3.75.

Living With a Disability

It comes as a shock to learn that, in the United States, there are ten millions of handicapped women. The number of crippled men is not given but it cannot be much less. And as conditions of life in the two countries are similar, it goes by inference that there must be a very large number indeed of disabled Canadians.

Such people, like their intact fellows, must live, work and play and none of these is particularly easy to the man or woman who lacks a hand or a foot, is partially paralyzed or is handicapped in some other way. To them, to their friends, to their families and to their doctors this book will be most welcome.

The first chapter is on "Taking Advice" and is addressed to the crippled and all those in contact with them. There is a table whereon progress in various skills can be recorded. This encourages the disabled person to strive for a goal and to persist towards still greater improvement.

The book guides the reader through the usual day. The chapter "Three Meals a Day" illustrates how food can be prepared and eaten by the aid of devices of all sorts. Some of these can easily be made at home. Others that must be bought can be purchased in confidence because they have all been thoroughly proven.

"Looking Your Best" follows the same plan. Pictures are large, clear and show how mutilated limbs can still be useful. The object is always to make the person (he or she is not always a patient) as independent as possible.

The chapter "Keeping Up Appearances" continues the topic of dressing, undressing, bathing, toilette, even to such important feminine activities as powdering the nose and straightening the lips; and masculine duties such as shaving. Pictures show how bathrooms can be arranged for comfort, convenience and safety.

Much of the doings of the business day are possible to the handicapped. Type-writing, 'phoning, reading, writing can be accomplished with little difficulty by means of fairly simple apparatus all of which is described and illustrated.

The man or woman who earned a living operating a machine may still be able to do so. Means for getting about indoors and out of doors are described.

There is a chapter entitled "The Conquest of the Kitchen" with pictures that show how all manner of things can be done. Ironing, even washing may be done with comparative ease. The sewing machine need not be laid aside.

The feeling of leisure hours is not forgotten. Weak arm-muscles need not prevent piano-playing. Devices are illustrated that will permit of card-playing, of controlling the radio, of fishing and a variety of other amusements.

There is an index and a list of addresses where certain forms of apparatus can be obtained.

The recent epidemic is likely to leave many disabled persons. Others will suffer from other causes. There are the cripples already with us. To all these this book will be most helpful.

The senior author is the Director of the Institute of Physical Medicine and Rehabilitation, New York University—Bellevue Medical Centre and assisting him is an assistant professor of clinical physical medicine and rehabilitation. Between them they have prepared a manual which will widely extend the valuable services rendered by the institutions to which they are attached.

Living With a Disability, by Howard Rusk, M.D., and Eugene J. Taylor. The Institute of Physical Medicine and Rehabilitation, New York University—Bellevue Medical Centre. Published by Blakiston in Canada, Doubleday Publishers, 105 Bond St., Toronto 2, Ont. Price $4.50.

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Excerpta Medica

That well established and highly esteemed periodical **Excerpta Medica** has added a new section to the already existing fifteen. The new section is devoted to Cancer and its related fields. It will be published monthly, will run between 700 and 800 pages of informative abstracts each year including a monthly index of authors and a classified subject and authors index on completion of each yearly volume.

Volume I will be made up of six monthly issues (July to December, 1953) and the price is $5.00. Subsequent volumes will consist of twelve monthly issues and the price will be $10.00 a year.

There is a world-wide and growing demand for an abstract journal covering this most important subject. Publication is now possible thanks to grants from the National Cancer Institute and the American Cancer Society.

Volume I, Number I, is 96 pages. The abstracts are classified under twenty-five main headings each of which has several sub-headings. There are 424 abstracts.

Address:: Excerpta Medica Service Corporation, 280 Madison Ave., New York 16, N.Y.

Professional Representative: Mr. A. C. Payne, 49 Harmon Ave., St. James, Man.

College of Physicians and Surgeons of Manitoba

Specialist Register

Applications Under Section 3 of the By-law must be in the hands of the Registrar at 604 Medical Arts Building, Winnipeg, prior to January 1st, 1954.

Registration Committee—March 24, 1953

Certificates of Registration Deferred

Robert Murray Holmes, L.M.S.S.A., London, 1946.

Louis Norman Gleeson, L.M.S.S.A., London, 1951; M.D., U. Zurich, 1952.

Certificates of Registration Granted

Cyril Hamwee, M.B., Ch.B., Victoria, U. Manchester, 1939; M.R.C.S., England, 1939; L.R.C.P., London, 1939.

Gilbert McIlwrick Forsyth, M.B., Ch.B., U. Edinburgh, 1939; M.R.C.O.G., 1948.

Registration Committee—April 7, 1953

Enabling Certificate Deferred

Stefan Friedrich, M.D., U. Vienna, 1939.

Enabling Certificates Granted (if certain conditions fulfilled)

Angus William Coshan, M.B., B.S., U. Madras, 1945.

Denny Mong-Hwa Hwang, M.D., West China Union U., 1945.

Enabling Certificates Granted

Gerhard Conradi, M.D., Friedrich-Schiller U., 1942.

Eugene Mario Edmund Morigi, M.D., U. Bologna, 1947.

Erich Franz Josef Rueben, M.D., Heidelberg U., 1951.

Certificates of Registration Deferred

Robert Murray Holmes, L.M.S.S.A. London, 1946.

Robert Alistair Laing, M.B., Ch.B., U. Aberdeen, 1950.

Certificate of Registration Granted

Timothy Daly, M.B., B.Ch., National U., Ireland, 1945.

Registration Committee

May 5, 1953

Enabling Certificate Deferred

Stefan Friedrich, M.D., U. Vienna, 1939.

Enabling Certificate Granted

Alice Hsiang-lien Hsu, M.D., Peiping Union Medical College, 1937.

Certificate of Registration Confirmed

Iain Morrison Ross Laing, M.B., Ch.B., U. Aberdeen, 1951.

Certificates of Registration Granted

John McNaught Lockie, M.B., Ch.B., U. Edinburgh, 1934; D.M.R. (D), U. London, 1952.

Isaac Bernard Barclay, M.R.C.S., Eng., 1911; L.R.C.P., Lond, 1911; D.P.H., U. Bristol, 1917; D.M.R.E., U. Cambridge, 1930.

Applicants Who Did Not Receive Basic Sciences Certificates of Credit Before the Act Was Repealed, April 18, 1953

The Registrar presented 28 applications, which were received from the Registrar's Office, University of Manitoba, from doctors whose documents were being considered by the Basic Sciences Committee when the Act was repealed. Twelve were from Manitoba, 10 from Quebec, 3 from Ontario, and 3 from Europe. The Chairman presented the record of marks obtained by eight candidates who wrote the Basic Sciences examinations in April, and it was considered good evidence of the necessity to have the basic sciences evaluated. The Committee agreed that the University should be asked, under Section 75 of the Medical Act, to set basic sciences examinations similar to the previous Act, and to establish a Committee on Credentials to review qualifications in subjects other than basic sciences. The Committee agreed that a meeting of the Council should be called, and that a recommendation from this Committee was necessary.

Recommendation to be Forwarded to Council

The Registration Committee expressed regret at the repeal of the Basic Sciences Act. The Committee has a large number of applications in which there is considerable doubt as to the qualifications in basic sciences subjects. Information from the University of the failure of a number of these applicants to pass basic sciences examinations is on file.

It is therefore recommended to Council that the University be asked to continue to provide assessment in the basic sciences, and/or examinations when requested, under the authority of Section 75 of the Medical Act, through a committee of the Senate equivalent to the former Basic Sciences Committee.

The Council might also give consideration to requesting the Senate of the University to assist in the assessment of medical documents of applicants for registration and/or Enabling Certificates in subjects other than the basic sciences, through the present Senate Committee on Credentials, Faculty of Medicine.

Council Meeting
May 23rd, 1953

A Special Meeting of the Council of the College of Physicians and Surgeons of Manitoba was held Saturday, May 23rd, 1953, at 10 a.m., D.S.T., in the Medical College, Winnipeg.

The President, Dr. C. E. Corrigan, called the meeting to order.

1. Roll Call

The following members were present:

Doctors C. E. Corrigan, President; T. W. Shaw, Vice-President; T. H. Williams, Treasurer; A. R. Birt, W. J. Boyd, B. Dyma, A. P. Guttman, G. H. Hamlin, Ed. Johnson, P. Johnson, F. K. Purdie, F H. Smith, C. B. Stewart, C. H. A. Walton, Wm. Watt and M. T. Macfarland, Registrar.

2. Reading of the Minutes and Their Approval

The President advised that mimeographed copies of the minutes of the Annual Meeting of Council held October 11th, 1952, had been forwarded to each member of Council.

Motion: "THAT the minutes of the Annual Meeting of Council held October 11th, 1952, be accepted as having been read." Carried.

Business Arising From Minutes of Council Meeting Held October 11, 1952

A. Appointment of Auditors

Motion: "THAT Price Waterhouse & Co. be appointed auditors for the year 1952-1953." Carried.

3. Reports of Officers and Their Consideration

A. Treasurer's Report

Your treasurer begs to report as follows:

Investment Trust Account: There are $60,000 in Dominion of Canada 3% fully registered bonds in this account. There have been no bonds purchased or matured since our last meeting. There was paid from the interest of this account the sum of $750.00 annual grant to the Medical Library for the current year. There is at present a sum of $2,122.55 accrued bond earnings and interest in this account.

Gordon Bell Memorial Trust Account: Regular monthly payments of $150.00 have been made to Dr. Colin Ferguson from this account. One further payment of $150.00 is due to be made in June completing the grant made. There is at present $371.93 in this savings account and there are $25,500 in Dominion of Canada fully registered 3% bonds in this account. If any grant is made from this account this year it will be necessary to sell some bonds to meet it.

Current Account: The credit balance in this account as at April 30th amounts to $7,293.92 as compared with $4,303.81 one year ago. This favorable balance is largely due to registration fees which continue at a high level up to the present. Your treasurer would again remind you that there is an abnormally large income from this source which we cannot expect to continue permanently. Documentation fees and the increase of annual dues to $5.00 contributed to a lesser extent toward the total income.

Our current expenses for the half year are also somewhat increased due to additional office help and raised salaries to them. No salary increase to your two paid medical staff has been made for some time.

Since this current account is non-interest bearing your treasurer would request authority be given to the Finance Committee to invest part of the funds in this account in interest bearing securities and placed in the Investment Trust Account and also that surplus in the Investment Trust Account be invested in interest bearing securities in that account. The reason that action has been delayed in this matter was owing to pending legislation and its possible widening of the variety of investment allowed us. Security of investment must continue to be a major factor in making decisions as to investments.

Respectfully submitted,
T. H. Williams, M.D., C.M.

Motion: "THAT the Treasurer's Report be accepted." Carried.

4. Reports of Standing Committees and Their Consideration

A. Executive Committee

The Chairman, Dr. C. B. Stewart, advised there had been one meeting of the Executive Committee held since the October Council Meeting (March 11, 1953), and mimeographed copies of the minutes had been distributed to each member of Council.

Motion: "THAT the minutes of the Executive Committee be accepted as having been read." Carried.

Business Arising From Minutes of Executive and Legislative Meetings

(1) Amendments to Medical Act

The Chairman of the Legislative Committee, Dr. W. J. Boyd, advised the amendments to the Medical Act had been drafted, and approved at a joint meeting of the Executive and Legislative Committees, at which the solicitor was present, and the Committee of Fifteen. The amendments were passed by the Manitoba Legislature on Saturday, April 18, 1953, and Royal assent was given. Copies of the Bill to amend the Medical Act were given to each member of Council.

Election of Council

Dr. C. H. A. Walton pointed out that with the new method of election outlined in the amendments, it would be necessary to have an election within one year.

Motion: "THAT the machinery for an election of Council be set up after the Annual Meeting of Council in October, 1953." Carried.

Amending By-laws

The Registrar suggested that with the amendments to the Medical Act, the By-laws of the College would require some changes. It was agreed that the Legislative Committee be empowered to review the By-laws to bring them into line with the amended Medical Act, and report to Council.

(2) Registrars Meeting

The Registrar advised that he had been given permission at the Executive Meeting, March 11, 1953, to attend the meeting of the Registrars on Thursday, June 18, 1953, and arrange for a luncheon for the Registrars. Since that time a buffet luncheon has been arranged for the same day by the Armed Forces Section C.M.A., and it was possible that some of the Registrars would like to attend.

The Registrar was authorized to arrange for a luncheon for any of the Registrars who would be able to attend.

(3) Community Chest and Council of Greater Vancouver

The Registrar advised that after the meeting of the Executive Committee, March 11, 1953, he had forwarded a copy of the report of the Committee which studied the proposals of the Community Chest and Council of Greater Vancouver re proposed amendments to the Opium and Narcotic Drug Act, to the Community Chest and Council of Greater Vancouver, and the Narcotics Division, Ottawa. A letter of thanks, expressing appreciation of the time and study given to this matter, was received from the Immediate Past-President.

(4) Medical Registration Council, Dublin, Eire

A further communication, under date March 9, 1953, was received from the Medical Registration Council, Dublin, advising that prior to the passing of their 1951 Amending Act and the British Act of 1950, practitioners registered in the Commonwealth and Foreign Lists of the British Register were eligible for registration in Eire on payment of the required fee, but, with the passing of these Acts that privilege was withdrawn, and Section 26 of their Act requires an official agreement as to reciprocity in the matter of Registration. The Registrar of the Dublin Medical Registration Council inquired whether the Council of the College of Physicians and Surgeons of Manitoba, would be prepared to make a formal arrangement so that their Council would be in a position to ask the Government to make an Order to apply Section 26 to Manitoba.

Motion: "THAT since the Medical Registration Council, Dublin, Eire, terminated the former arrangement, that the request for reinstatement of reciprocal registration should originate with that body." Carried.

(5) Cancer Relief and Research Institute

The Registrar advised that the Institute had been reorganized under Director, Medical Services; Comptroller; and Director, Radiation Laboratories and Research; also an Executive Officer and Chairman of Staff Committee, who will liaise with the other three groups. There have been no names mentioned for these positions.

Dr. Walton advised that he thought the matter of radium lists would adjust itself since the Institute is negotiating to bring over a qualified radio-therapist, and it is expected that the use of radium will be modified considerably if suitable persons head it.

(6) Dr. .....

Dr. Ed. Johnson, Chairman of the Discipline Committee, advised he had considerable correspondence with this doctor offering assistance, but on two occasions he had failed to keep appointments to meet with Dr. Macfarland and himself. Dr. .....'s name has now been entered on the "Restricted List" of the Narcotic Division.

(7) Gordon Bell Memorial Committee

The Registrar reported that Dr. Colin Ferguson had clarified his status in the United States, and he had returned to complete his term at Children's Hospital, Boston, and that the outstanding cheques had been forwarded. Under the present arrangement Dr. Ferguson will receive one more cheque from the Gordon Bell Memorial Account. The Registrar advised there were no applicants for the forthcoming year.

B. Registration Committee

Report of the Registration Committee

1. Since the annual meeting of Council the Registration Committee has met on seven occasions..

2. Twenty-two Enabling Certificates were granted. Certificate of Registration was authorized in thirteen instances. Five Certificates of Licence were granted. There were eight deferments of applications for Enabling Certificates. Eight applications for Certificate of Registration were deferred. Total number of registrations in Manitoba for the period 11 October, 1952 to 23 May, 1953, was forty-nine.

3. The Committee continues to be concerned with a number of difficult and diverse problems. Four applications were of particular importance and deserve special mention.

(a) Dr. .....

Dr. ..... was unable to present to your Committee the usual evidence of a minimum internship. However, as he had served in general hospitals with the army during the war and had also served for brief periods in two Quebec hospitals and as he was licensed to practice in the province of Saskatchewan where he practised for some time, it was agreed to register him on an affidavit certifying to the above experience in detail. Dr. ..... is now practising in Saskatchewan.

(b) Dr. .....

This man had the L.M.S.S.A. qualification from London in 1946. He came to ..... and set up practice without registration apparently being under the impression that his registration with the General Medical Council of Great Britain was sufficient. However, when he attempted to write prescriptions for narcotics ..... his problem of lack of registration in Manitoba was brought to attention. In his application he had no evidence of interneship and his application was deferred pending an interview at the next meeting of the Committee, which was arranged for the ninth of March. He did not appear for this interview but finally met the Committee on the twenty-fourth of March. The interview was very unsatisfactory and Dr. ..... was unable to give any acceptable evidence of interneship. He said that he had written to the several hospitals in England in which he had served but had received no replies. The Registration Committee asked him to present a sworn affidavit of his hospital service. Dr. ..... objected to this request but finally did produce an affidavit which was most unsatsfactory because it failed to mention dates of service. Subsequently the Registrar received information from ..... indicating that Dr. ..... service in the Department of Health of that Province had been unsatisfactory and that he had left while still under contract and without release. At the last meeting of the Registration Committee on the fifth of May, further information had come to hand which indicated that Dr. ..... service in various hospitals was of a very brief nature and had been unsatisfactory in at least one instance. It was felt important to obtain more definite information and air mail letters had been sent to all of the institutions named in Dr. ..... application in an attempt to obtain further information. In the meantime Dr. ..... remains unregistered. I understand that he has now withdrawn his application and plans to leave the province.

The problem of this man's application is given in some detail because it proved to be a most distressing and difficult matter and it is the feeling of the Committee that Dr. ..... is probably not a suitable registrant. Withdrawal of his application is perhaps a fortunate solution.

(c) Dr. .....

The application of Dr. ..... was first deferred in January because of lack of evidence of interneship and because of information which led the Committee to believe that Dr. ..... was not in good health and that there was a problem involving the misuse of drugs. The possibility of issuing him a temporary licence if he was under the supervision of another doctor was entertained but the doctor who might have supervised his work would not agree to the arrangement. Accordingly, Dr. ..... was notified that he did not qualify for registration because of his lack of interneship and the file was passed to our legal advisor. Since this matter has been under consideration, the amendments to the Medical Act included a clause concerning general fitness to practice medicine and it is probable that this clause will permit a more careful and accurate assessment of such applicants as above. Dr. ..... now has an appointment in a Winnipeg Hospital where he is working under supervision and the reports from the hospital are satisfactory. It is probable that Dr. ..... status will be reviewed at the end of a year of interneship.

(d) Dr. .....

The problem of Dr. ..... has been referred to in previous meetings of Council. The Registration Committee through the Executive of Council have arranged to place the matter entirely in the hands of our solicitor. Dr. ..... refused to write the Basic Science examinations as previously required but since the repeal of the Basic Science Act this obstacle to his application has been removed. Your Committee continues to be very uncertain as to what action should be taken in regard to this man. His difficult behaviour and his threats can only lead one to believe that he is a most unfit person to be licensed to practice in this province. However, whether this opinion is sufficient to continue to refuse an enabling certificate so that he may write the Medical Council of Canada examinations is the question.

The problems of the above four men will be referred to in other reports of this Council.

4. With the new amendments to the Medical Act the requirements for registration or enabling certificates will be a little more clear particularly in regard to the matter of satisfactory interneship.

All of which is respectfully submitted.

C. H. A. Walton, M.D.

May 23, 1953.

Motion: "THAT the report of the Registration Committee be adopted." Carried.

The Registrar reported that since the last meeting of the Registration Committee, he had received several replies from the various hospitals in which Dr. ..... advised he had been employed, and he outlined various inquiries received concerning Dr. ..... Since Dr. ..... has

withdrawn his application, the matter is considered closed.

The Registrar reported that Dr. ..... had forwarded through his solicitor the required fee and had agreed to write the examinations in Winnipeg, and that an Enabling Certificate had been forwarded to our solicitor to be forwarded to Dr. .....

Dr. Walton also outlined the application of Dr. ..... He graduated from l'Aurore University, 1941, and had interned for three years at Hotel-Dieu Saint Vallier, Chicoutimi, Quebec. The Committee agreed that an Enabling Certificate be granted to Dr. ..... provided the examinations be taken in Winnipeg. Dr. ..... agreed to take the examinations in Winnipeg, but wished to write them in French since his training had been in French. It was agreed that the object of having these doctors write in Winnipeg was an interview, and that an Enabling Certificate should not be granted to someone who has never been seen, and Dr. ..... was advised to come to Winnipeg for a personal interview at which time the Enabling Certificate may be issued. Dr. ..... now asks for assurance that an Enabling Certificate would be granted if he comes to Winnipeg, and Dr. Walton requested direction from Council. The Council agreed that Dr. ..... be required to write the examinations in Winnipeg, or appear for a personal interview.

Motion: "THAT the Council approves the action taken by the Registration Committee in connection with the above applications." Carried.

Business Arising From Minutes of Registration Committee Meetings

(1) Resolution Re Repeal of Basic Science Act

Dr. Walton reported that the Basic Sciences Act was repealed on April 18th, and the Committee had had a great deal of assistance in evaluating the applicants for Enabling Certificates in regard to basic sciences. He advised that in the April basic sciences examinations there had been a number of failures, and with the repeal of the Basic Sciences Act there is no method of evaluating documents. The Committee felt that there should be some substitute to the Act and the following recommendation was passed at the meeting held May 5th. (Refer Registration Committee minutes).

Motion: "THAT Council adopts the recommendation of the Registration Committee in requesting the University of Manitoba to assess documents presented by applicants for registration and/or enabling certificates." Carried.

After considerable discussion the following motion was carried to be forwarded to the President of the University of Manitoba for presentation at the Senate meeting to be held June 4th, 1953.

Motion: "WHEREAS, the Council of the College of Physicians and Surgeons through its Registration Committee is required to consider a large number of applications for medical licensure in Manitoba, from candidates who are not graduates of the University of Manitoba, and

WHEREAS, the College of Physicians and Surgeons may register anyone registered under the Canada Medical Act or by the General Medical Council of Great Britain, and

WHEREAS candidates who do not possess such qualifications usually apply to the College of Physicians and Surgeons for an enabling certificate to permit the writing of the examinations of the Medical Council of Canada, and

WHEREAS the College of Physicians and Surgeons often has great difficulty in evaluating the qualifications of such applicants for enabling certificates, and

WHEREAS the recently repealed Basic Sciences Act provided a most valuable measure of assessment, and

WHEREAS, under Section 75 of the Medical Act the Senate of the University of Manitoba is named as the sole examining body in Medicine in this province and has the power to examine evidence of qualification and to examine or otherwise assess a candidate, therefore

BE IT RESOLVED THAT the Council of the College of Physicians and Surgeons request the Senate of the University of Manitoba to set up the necessary arrangements so that candidates referred to it by the College of Physicians and Surgeons may have their qualifications assessed by examination or otherwise and that the Senate issue to such candidates a certificate under the seal of the University that the Senate is satisfied that the person mentioned is suitably qualified to proceed to the examinations of the Medical Council of Canada." Carried.

C. Education Committee

No meeting.

D. Finance Committee

There have been no meetings of the Finance Committee owing chiefly to the impending changes in the Medical Act which might have a bearing on the investment of funds and other financial matters. A request was received by the Executive that the C.P. & S. advance One Thousand Dollars ($1,000.00) to the Committee of preparation for the C.M.A. meeting, and, on the approval of the Executive of the C.P. & S., a cheque was accordingly made out to Dr. Schoemperlen. This may be in part returned, if not all required to meet deficits.

Respectfully submitted,
T. H. Williams, M.D., C.M.

Motion: "THAT the report of the Finance Committee be adopted." Carried.

Motion: "THAT the Finance Committee be empowered to take advantage of the widened power for investments under Section 89 of the amended Medical Act; that the surplus in the non-interest-bearing Current Account, and Investment Trust Account, be invested leaving sufficient funds in the accounts for current use; and that the Finance Committee investigate the possibility of the sale of some of the 3% bonds and reinvestment in approved securities." Carried.

E. Legislative Committee

Refer report of Executive Committee.

F. Library Committee

There have been two recent meetings of the Library Committee attended by your representative. Matters of staff replacement, and hours on Saturdays and purchase of new books and periodicals were dealt with. There were sufficient funds for the purchase of those approved. The C.P. & S. has made the customary donation of Seven Hundred and Fifty Dollars ($750.00) to the Medical Library for the current year.

Respectfully submitted,
T. H. Williams, M.D., C.M.

Motion: "THAT the report of the Library Committee be adopted." Carried.

G. Discipline Committee

Dr. Johnson outlined the cases of Dr. ..... and Dr. ..... . The case of another doctor was presented who had lost his hospital privileges, has no membership in the Canadian Medical Protective Association, has not been in his office for three months, and his telephone has been discontinued. No formal complaint has been made, and the Council considered that such cases should be reported to the Discipline Committee. Dr. Johnson inquired whether the Council would give direction to the Discipline Committee, since the Act has been amended, particularly with reference to communications which are received from the Narcotic Division. He inquired whether the Discipline Committee should insist that where a complaint has been made, the physician complained against should be required to come before the Committee and report on the problem. He thought some good might result from it.

The Council agreed that it would be good public relations, under Section 45 of the Medical Act, to order the appearance of any member against whom a complaint has been made.

H. Taxing Committee

No report.

5. Reports of Special Committees and Their Consideration

A. Representatives to Manitoba Medical Association Executive

Dr. C. B. Stewart advised he had attended most of the meetings of the Manitoba Medical Association Executive, but had nothing special to report.

B. Trustees of the Gordon Bell Memorial Fund

No further report.

C. Representatives to the Committee of Fifteen

Dr. W. J. Boyd reported that the Committee of Fifteen met on two occasions to consider certain changes in the Basic Sciences Act, the Workmen's Compensation Act, and the Medical Act. The Committee endorsed the changes to the Medical Act, and consideration was given to the stand which the Committee would take in the event that definite action was to be taken in respect to the Basic Sciences Act, and a committee was struck to draw up a brief to present to the Law Amendments Committee. The Government introduced the changes to the Basic Sciences Act during the last days of the Legislature, and there was no time to contact the members of the Legislature before the first and second reading to Bill 84, an Act to repeal the Basic Sciences Act, was given. Mr. Laidlaw drew up a brief and this was presented by him, but third and final reading was given to the Bill, and Royal Assent given.

Motion: "THAT the report of the representatives to the Committee of Fifteen be adopted." Carried.

The Registrar presented the brief prepared by Mr. Laidlaw, and a letter received from Mr. Laidlaw under date April 20th, in which it was suggested that the College or the Manitoba Medical Association consider setting up an active public relations committee to consider ways and means of selling the medical profession to the public, even to the extent of consulting some outside agency as to the most effective method of doing so. He suggested that when the new government takes office, a liaison with the new Minister of Health and Public Welfare be established at once.

Motion: "THAT the Manitoba Medical Association be requested to appoint a member of the Council of the College of Physicians and Surgeons to the Public Relations Committee, M.M.A." Carried.

D. Representative to the Committee of Selection in Medicine on Student Selection

No meeting.

E. Representatives to the Medical Council of Canada

No meeting.

F. Representative to the University Senate

1. I attended the meetings of the Senate of the University and no problems of special interest to this College came up other than the repeal of the Basic Sciences Act in April of this year. The Basic Sciences Committee continued until that time to deal with many applications for standing in the basic sciences. The usual examinations were held early in April and there were a large number

of failures in various subjects. Since the Basic Sciences Act was repealed the Committee has ceased to function.

2. I have expressed my opinion in previous reports that the Basic Sciences Committee served a most useful purpose and was of direct assistance to the College in screening candidates for enabling certificates and licensure. I propose to submit a resolution later dealing with this matter.

3. The School of Nursing Education continues to carry on with an uncertain future and is providing a needed post graduate education in Public Health and nursing supervision.

All of which is respectfully submitted.

C. H. A. Walton, M.D.

Motion: "THAT the report of the representative to the University Senate be adopted." Carried.

G. Representative to the Cancer Institute

Refer to minutes arising from Executive Committee meeting.

H. Representatives to the Liaison Committee, M.M.A., C.P. & S.

The Registrar reported that the Manitoba Medical Association has some communications on file concerning personnel which may make a meeting of the Liaison Committee necessary in the near future and decisions may require ratification by President, Executive Committee or Council.

I. Representative to the Canadian Arthritis and Rheumatism Society

The Registrar advised that the Medical Advisory Board is concerned with the operation of a new centre at 442 William Avenue, where patients are receiving physio-therapy treatments. A drive for funds is now under way.

J. Representatives to the Specialist Committee

The Committee has not met since the last meeting of Council. Further announcements have been published in the Manitoba Medical Review and it is expected that the Specialist Committee will be meeting shortly to deal with the accumulated applications.

All of which is respectfully submitted.

C. H. A. Walton, M.D.

6. Election of Officers and Standing Committees

Not applicable at this meeting.

Election of Special Committees

A. Representative to the University Senate

Motion: "THAT our representative to the University Senate be Dr. C. H. A. Walton." Carried.

7. Reading of Communications, Petitions, etc., to the Council

None.

8. Inquiries

None.

9. Notices of Motion

None.

10 Motions of Which Notice Has Been Given at Previous Meeting

None.

11. Unfinished Business

12. Miscellaneous and New Business

A. Appointment of Interneship Committee.

Dr. C. E. Corrigan pointed out that under the Medical Act, the College is given power to approve hospitals for interneship for the purpose of registration in this Province, and it would be necessary to set up a committee for this purpose. He stated that for sometime certain hospitals have been trying to restrict the type of practice carried on by staff members, and the fees they collect. Hospitals are private institutions, and the question is whether restrictions of hospitals would be an infringement of the Medical Act. A letter under date April 27th, was presented from the solicitor. Dr. Corrigan suggested that Council might wish the committee, appointed to approve the type of facilities provided by various hospitals, to refer to matters other than academic and teaching facilities. It was not considered necessary to appoint a committee before the Annual Meeting, or until such time as the Faculty of Medicine, University of Manitoba, decides to graduate students at the end of the fourth year.

It was reported that this question might come up again in connection with a health survey being carried on by the Provincial Government. It had been suggested that where there has been abuse of the use of a medical nursing unit, the matter be referred to a committee of both this College and the Department of Health and Public Welfare.

B. Payment of Janitor

Motion: "THAT the sum of Five Dollars ($5.00) be paid to the janitor for his services at this meeting." Carried.

C. Amount to be paid to Council Members for This Meeting

Motion: "THAT the amounts paid to members of Council for attendance at this meeting be the usual rate." Carried.

D. Date of Next Council Meeting

Motion: "THAT the date of the Annual Council Meeting be left to the discretion of the Executive Committee." Carried.

E. Adjournment

Motion: "THAT the meeting be adjourned." Carried.

Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1953 Oct. 4 to Oct. 31,'53	1953 Sept. 6 to Oct. 3,'53	1952 Oct. 5 to Nov. 1,'52	1952 Sept. 7 to Oct. 4,'52	Total Jan. 1 to Oct. 31,'53	Total Jan. 1 to Nov. 1,'52
Anterior Poliomyelitis	281	572	121	218	2189	760
Chickenpox	49	45	164	57	1039	1187
Diphtheria	0	0	0	0	4	2
Diarrhoea and Enteritis, under 1 yr.	26	38	13	17	156	146
Diphtheria Carriers	0	0	0	0	0	0
Dysentery—Amoebic	0	0	0	0	0	0
Dysentery—Bacillary	3	4	3	5	19	24
Erysipelas	2	1	0	1	27	13
Encephalitis	2	3	0	2	9	5
Influenza	12	8	13	12	218	152
Measles	46	10	162	98	2323	1390
Measles—German	1	0	0	1	40	13
Meningococcal Meningitis	3	0	2	2	27	16
Mumps	27	30	67	64	887	1193
Ophthalmia Neonatorum	0	0	0	0	0	1
Puerperal Fever	0	0	1	0	0	2
Scarlet Fever	21	17	35	18	327	569
Septic Sore Throat	8	4	2	3	87	73
Smallpox	0	0	0	0	0	0
Tetanus	0	0	1	0	2	4
Trachoma	0	0	0	0	0	0
Tuberculosis	62	45	60	80	699	848
Typhoid Fever	0	0	0	2	1	5
Typhoid Paratyphoid	0	0	0	0	0*	2
Typhoid Carriers	0	0	0	0	0	0
Undulant Fever	0	0	0	0	9	5
Whooping Cough	23	17	14	9	147	402
Gonorrhoea	113	128	87	108	1063	1116
Syphilis	4	5	7	9	69	98
Infectious Jaundice	20	25	8	11	259	52
Tularemia	0	0	0	0	2	4

Four Week Period, October 4th to October 31st, 1953

DISEASES (White Cases Only) *Approximate population.	*798,000 Manitoba	*861,000 Saskatchewan	*3,825,000 Ontario	*2,952,000 Minnesota
Anterior Poliomyelitis	281	124	313	212
Chickenpox	49	222	801	....
Diarrhoea & Enteritis, Under 1 yr.	26	8	....	....
Diphtheria	....	3	....	10
Diphtheria Carriers	....	....	....	....
Dysentery—Amoebic	....	....	1	....
Dysentery—Bacillary	3	12	15	21
Encephalitis Epidemica	2	5	1	2
Erysipelas	2	1	3	....
Influenza	12	4	30	6
Infectious Jaundice	20	31	31	91
Measles	46	109	210	6
German Measles	1	2	49	....
Meningitis Meningococcus	3	1	8	2
Mumps	27	96	365	....
Ophthal. Neonat.	....	....	....	....
Puerperal Fever	....	....	....	....
Scarlet Fever	21	19	163	34
Septic Sore Throat	8	....	4	58
Smallpox	....	....	....	....
Tetanus	....	....	....	....
Trachoma	....	1	....	....
Tuberculosis	62	45	95	126
Typhoid Fever	....	....	3	3
Typh. Para-Typhoid	....	1	....	....
Typhoid Carrier	....	....	....	....
Undulant Fever	....	....	1	9
Whooping Cough	23	24	187	15
Gonorrhoea	113	....	184	....
Syphilis	4	....	67	....

DEATHS FROM REPORTABLE DISEASES

For the Month of October, 1953

Urban—Cancer, 56; Pneumonia, Lobar, 2; Pneumonia (other forms), 8; Pneumonia of Newborn, 3; Poliomyelitis, 7; Syphilis, 2; Tuberculosis, 1; Meningococcal Infections, 1. Other deaths under 1 year, 28. Other deaths over 1 year, 233. Stillbirths, 13. Total, 274.

Rural—Cancer, 26; Lethargic Encephalitis, 1; Pneumonia, Lobar, 3; Pneumonia (other forms), 11; Poliomyelitis, 1; Syphilis, 1; Tuberculosis, 4; Dysentery, 1; Diarrhoea & Enteritis, 2; Infectious Hepatitis, 1. Other deaths under 1 year, 18. Other deaths over 1 year, 165. Stillbirths, 12. Total, 195.

Indians — Cancer, 2; Influenza, 3; Pneumonia, Lobar, 1; Pneumonia (other forms), 1; Poliomyelitis, 1; Diarrhoea & Enteritis, 3. Other deaths under 1 year, 2. Other deaths over 1 year, 6. Stillbirths, 2. Total, 10.

♦

Poliomyelitis is definitely on the decrease at the time of writing (November 10th), but a total of 2,254 cases have been reported. Eighty-two deaths of Manitoba cases have occurred. Over one-half of the cases show some degree of paralysis and at least sixty are still in respirators. Considering the 177 respirator cases this year, one-third have died, one-third have recovered sufficiently to get out of the respirators and one-third are still in.

Infectious Jaundice has been quite prevalent in many parts of the province this year — in fact many provinces and states have experienced increases.

Venereal Diseases, Syphilis again this year shows a definite decrease and **Gonorrhoea** a very slight decrease.

Detailmen's Directory

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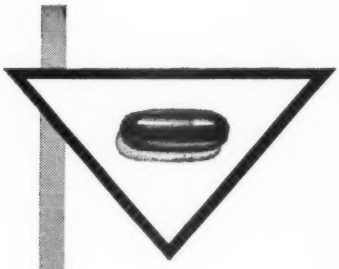

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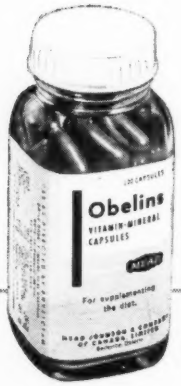

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Annual Subscription $4.00

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The Manitoba Medical Review is published the first of each month, in 10 Yearly Issues — Jan., Feb., Mar., April, May, (June-July), (Aug.-Sept.), Oct., Nov., Dec.

Manuscripts must be typewritten, double spaced and the original copy.

Illustrations and engravings are to be supplied by the contributor. Halftones, 120 screen.

Closing Dates for Articles is the 1st of the month preceding date of issue.

Reprints may be ordered at the time the galley proof is returned. Quotations on request.

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